11200

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-d)

CERTIFICATE OF DEATH

11700

Reg. Dist. No. 10

1. PLACE OF DEATH:
County: Allegany
City or town: Barrellsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Barrellsville R.F.D. Savage, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Theodore Michael Abrecinas

3.(b) Social Security Number: 208-09-1867

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia Radzwillick
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years	Months	Days	If less than one day
63	1881 [illegible]	17	..... hrs. ..... min.

9. Birthplace: Moscow Russia
(Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mines
FATHER 12. Name: Louis Brenn
13. Birthplace: " "
MOTHER 14. Maiden name: " "
15. Birthplace: " "
16. Informant: Celestine Abrecinas
Address: Mt. Savage Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-4-1946 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Mt. Savage Md.
18. Funeral director: Jacob Baker
Address: Frostburg, Md.
19. 1-2 1946 (Date rec'd by registrar) Vernon McDermitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31st 1945 at 6:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to December 31 1945 and that I last saw him alive on December 31 1945

Immediate cause of death	DURATION
Myocarditis	5 days
with an associated vascular Hypertension	
Due to	
Due to	
Other conditions Bronchial Asthma	20 years or more

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: William E. Moseley M.D.
M. D. or other
Address: Mt Savage Md. Date signed 1-2-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS
Cumberland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11701

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:
467 Baltimore Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 467 Baltimore Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Daisy Mae "George" Andrews

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife Matthew Andrews

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 16, 1882

8. AGE:	Years	Months	Days	If less than one day
	63	7	17	..... hrs. ..... min.

9. Birthplace Barton, Allegany, Md.
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name Theopolis George
13. Birthplace England

MOTHER
14. Maiden name Mary Saxton
15. Birthplace England

16. Informant Mrs. Sophia Hott
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 6 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetary

Location Cumberland, Md.

18. Funeral director John F. Hofer

Address Cumberland, Md

19. Dec 5, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Dec 3 1945 and that I last saw h.. alive on Dec 3 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. A. Trewaski M.D.
M. D. or other

Address Cumberland md Date signed Dec 5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1945- 14- 33
1882- 4- 16
63 7 17

11702

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 1

1. PLACE OF DEATH:
County: Allegany
City or town: Little Orleans
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 / yrs.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Little Orleans
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME John Frederick Appel

3.(b) Social Security Number none

4. Sex: M
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Minnie A. Appel
6.(c) If alive, give age: 74 years
7. Birth date of deceased (mo., day, yr.): April 14, 1861
8. AGE: Years: 84 Months: 8 Days: 1 If less than one day: ____ hrs. ____ min.
9. Birthplace: Little Orleans Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: General Carpenter work

FATHER
12. Name: Henry Appel
13. Birthplace: United States

MOTHER
14. Maiden name: Hannah Slider
15. Birthplace: Town Hill, Maryland

16. Informant: Mason A. Appel
Address: Little Orleans Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 18, 1945 (month) (day) (year)
Cemetery or crematory: Little Orleans cemetery
Location: Little Orleans, Md.

18. Funeral director: Snyder-Rowland Funeral Home
Address: Hancock, Md.

19. Dec 16 1945 T. T. Mann per M.E.M. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1945, 12.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 13, 1945, to Dec. 15, 1945 and that I last saw him alive on Dec. 13, 1945

	DURATION
Immediate cause of death: arterio-sclerosis	5 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: /
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: / Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. A. Watson M.D.
M. D. or other
Address: Little Orleans Md. Date signed: 12/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

Dr. Tolson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11703

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 3 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 Laing Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME NELSON
Mr. Lewis Bailey

3.(b) Social Security Number 705-07-8678

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia ~~Bailey~~ Johnson

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): September 28 1871

8. AGE: Years	Months	Days	If less than one day
74	3	2	..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Retired B&O Fireman

11. Industry or business:

FATHER
12. Name: John Bailey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Custer
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 7 46 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem

Location: Cumberland

16. Funeral director: Louis Stein Inc

Address: Cumberland Md.

19 Jan 7 19 46 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30, 19 45, at 4:35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-2- 19 45, to 12-30- 19 45 and that I last saw h. alive on 12-30- 19 45

Immediate cause of death	DURATION
Carcinoma prostate ?	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Howard L Tolson md M. D. or other

Address: Cumberland Md Date signed 12-31-45

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

11704

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years

Hospital, Institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 28. Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107. Columbia St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Barnhill

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Theresa Barnhill

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 22 1850

8. AGE: Years	Months	Days	If less than one day
95	10	4	..... hrs. ..... min.

9. Birthplace: Scotland
(Town, county, and state)

10. Usual occupation: Retired Janitor

11. Industry or business: Star Dye Works

FATHER
12. Name: James Barnhill
13. Birthplace: Scotland

MOTHER
14. Maiden name: Mary Browning
15. Birthplace: Scotland

16. Informant: Mrs. Robert Barnhill
Address: 107. Columbia St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/45 (month) (day) (year)

Cemetery or crematory: St. Patricks Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec 27 1945 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1945, at 7-50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 24 1943, to 12-26 1945

and that I last saw him alive on 12. 2 1945

	DURATION
Immediate cause of death: Generalized Arteriosclerosis	
Due to: Infirmities of age.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F. F. Williams M. D. or other

Address: Cumberland Date signed: 12-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

11705

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mo.

Hospital, institution, or street address where death occurred: 510 Shriver Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 510 Shriver ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Terry Allen Beckman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Oct 16 1945

8. AGE: Years — | Months 7 | Days — | If less than one day: ... hrs. ... min.

9. Birthplace: Cumberland (Town, county, and state) Md.

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Carleton R Beckman

13. Birthplace: Md

MOTHER — 14. Maiden name: Edna B Kirschner

15. Birthplace: Md.

16. Informant: Carleton R Beckman

Address: 510 Shriver ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 18 '45 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem

Location: Cumberland md.

16. Funeral director: Louis Stein Sons

Address: Cumberland md

19. Dec 18 1945 (Date rec'd by registrar) Jos. B. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 1945 at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to Dec 16 1945

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Child found dead in bed	
No evidence of accidental	
Due to death. Had been	
well Stas premature	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: None. Ref

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: H. M. Eason M.D. M. D. or other

Address: 26 Seven St Cumberland Md. Date signed: 12/16/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

11706

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 yrs.

Hospital, Institution, or street address where death occurred:
Sylvan Retreat.

How long in hospital or institution? 44 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Allegany

City or town: ~~Cumberland~~ Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Catherine Bell.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE: Years: 82 | Months | Days | If less than one day: ... hrs. ... min.

9. Birthplace: Harpers Ferry, West Va.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Jacob P. Bell.
13. Birthplace: Virginia.

MOTHER
14. Maiden name: Mary Leighley
15. Birthplace: Virginia.

16. Informant: Edward Bell.
Address: Westernport, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 4, 1945 (month) (day) (year)

Cemetery or crematory: xxx Philos

Location: Westernport, Maryland.

18. Funeral director: W. Harold Fradelich Jr.

Address: Piedmont, West Va.

19. Dec 3, 1945 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-3- 1945 at 5:30a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1945 to 12. 3. 1945 and that I last saw h[illegible]ed alive on 12. 1. 1945

Immediate cause of death	DURATION
Arteriosclerosis	2
Due to Infirmities of age.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: J. F. Williams M.D. or other

Address: Cumberland Date signed: 12-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

CERTIFICATE OF DEATH

11707

Reg. Dist. No. 4

FILM No. I 00 JAN 11 1946

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? Ten days

2. USUAL RESIDENCE (HOME) OF DEATH: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. Bowman's Addition (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ~~Gus Bobo~~ Guss Wesley Bobo

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia E. Spencer Bobo

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): June 15, ~~1885~~ 1883

8. AGE: 62 Years	Months	Days	If less than one day
~~62~~ 63	6	12	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General Work

FATHER 12. Name: Bruce Bobo

FATHER 13. Birthplace: W. Va.

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace

16. Informant: Manuel Bobo

Address: Rt. 3, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 30, 1945 (month) (day) (year)

Cemetery or crematory: Zion Memorial Park

Location: Rt. 3, Cumberland, Md.

18. Funeral director: John L. Hofer

Address: Cumberland, Md.

19. Dec. 30, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27, 1945, at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15, 1945, to Dec 27, 1945

and that I last saw h~~im~~ alive on Dec 27, 1945

Immediate cause of death: Carcinoma	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D Kepler M. D. or other

Address: 122 Bedford St Date signed: 12/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

11708

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54

Hospital, Institution, or street address where death occurred:

Broadway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Samuel Allen Boucher

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lulu M. Boucher

7. Birth date of deceased (mo., day, yr.): June 8, 1861

6.(c) If alive, give age: ..... years

8. AGE:

Years	Months	Days	If less than one day
84	6	7	..... hrs. ..... min.

9. Birthplace: Grantsville, Garrett Co., Md.

(Town, county, and state)

10. Usual occupation: Doctor M.D

11. Industry or business

FATHER

12. Name: Josiah Boucher

13. Birthplace: Unknown

MOTHER

14. Maiden name: Lucretia Compton

15. Birthplace: Unknown

16. Informant: Mrs Lulu M. Boucher

Address: Barton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 17 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill

Location: Mason, Md

18. Funeral director: E. Lawson Swaim

Address: Westernport, Md

19. Dec. 17 1945 (Date rec'd by registrar) A. Grayn Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15th 1945, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 8th 1945 to Dec. 15th 1945 and that I last saw h... alive on Dec. 15th 1945

Immediate cause of death	DURATION
Coronary Occlusion	
History of influenza Dec 1st	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.

M. D. or other (

Address: Lonaconing, Md. Date signed: Dec. 17 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

11709

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 29 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: WESTERNPORT
(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 SPRUCE ST.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

MRS. ALICE GALES Bowser

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: Herbert Bowser

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): MAY 25 1878

8. AGE: Years	Months	Days	If less than one day
67	6	18	____ hrs. ____ min.

9. Birthplace: MARYLAND
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business:

FATHER
12. Name: [illegible] LOGSDON
13. Birthplace: Md?

MOTHER
14. Maiden name: ? Hoover
15. Birthplace: ?

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERIAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 10 1945 (month) (day) (year)

Cemetery or crematory: Philos Cemetary

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Dec. 7 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC. 7, 1945 at 7:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV. 8, 1945 to DEC. 7, 1945 and that I last saw h[illegible] alive on DEC. 7, 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to: Diabetes Mellitus	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 12-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

11710

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Railroad St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Brodbeck

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Jean Reynolds

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 16th 1857

8. AGE: Years: 88 | Months: 1 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany Co. Md. (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal mine

FATHER
12. Name: John Brodbeck
13. Birthplace: Germany

MOTHER
14. Maiden name: Caroline Rush
15. Birthplace: Germany

16. Informant: Mrs. John Brodbeck
Address: Lonaconing, Md.

17. Burial, cremation, or removal. Which?: Burial Date thereof: Dec 10th 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: W. Eichhorn

Address: Lonaconing, Md.

19. Dec. 8 1945 (Date rec'd by registrar) Dr. E. Donley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 7th 1945, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2nd 1945, to Dec 7 1945

and that I last saw h.... alive on Dec 5th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other

Address: Lonaconing, Md. Date signed: Dec. 8th 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

11718

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Route 1, Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Route 1, Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Bush

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 10, 1867

8. AGE: Years	Months	Days	If less than one day
78	8	28	..... hrs. ..... min.

9. Birthplace: County Waxford, Ireland
(Town, county, and state)

10. Usual occupation

11. Industry or business: home

FATHER
12. Name: Henry Bush
13. Birthplace: Ireland

MOTHER
14. Maiden name: Rose Kenney
15. Birthplace: Ireland

16. Informant: Mrs. John Byrne,
Address: Route 1, Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11, 1945 (month) (day) (year)

Cemetery or crematory: St. Michael's Cemetery

Location: Frostburg, Md.

18. Funeral director: J. J. Durst,
Address: Frostburg, Md.

19. Dec. 11 1945 Dr. E. Dow Flora
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: December 8th., 1945 at 4.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Prince H. Lowry, M. D.
M. D. or other

Address: Cumberland, Maryland. Date signed: 12-8-45

County Medical Examiner - Allegany Co.

11712

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 8 mo. 27 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Detmold St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Bonnie Sue Cameron

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	child

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 9th 1943

8. AGE:

Years	Months	Days	If less than one day
2	8	27	hrs. min.

9. Birthplace: Lonaconing Allegany, Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Arch G. Cameron

13. Birthplace: Lonaconing, Md

MOTHER 14. Maiden name: Margaret Lloyd

15. Birthplace: Frostburg, Md

16. Informant: Mrs. Arch Cameron

Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 8 45 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. Dec 8 1945 (Date rec'd by registrar) Dr. E. Ormsby Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6th 1945 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4th 1945, to Dec 6th 1945 and that I last saw h- alive on Dec 6 1945

Immediate cause of death	DURATION
Meningitis	
Influenza	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry W. Hodgson M.D. M. D. or other

Address: Lonaconing, Md Date signed Dec 6 45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

11713

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: East Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 1, Locust Grove
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bessie Canty

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widdw

6.(b) Name of husband or wife: Will H. Canty.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 16, 1887

8. AGE: Years	Months	Days	If less than one day
58	5	15	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: own Home

MOTHER FATHER 12. Name: ~~dead~~ Harvey Baker

13. Birthplace: md.

MOTHER 14. Maiden name: ~~dead~~ Emma Dellinger

15. Birthplace: md.

16. Informant: Mrs Myrtle Bryson

Address: Cumberland md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/46 (month) (day) (year)

Cemetery or crematory: St Peter & Paul's Cem.

Location: Cumberland Md.

16. Funeral director: Lewis Stine Sec.

Address: Cumberland Md.

19. Jan 3 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/31 1945, at 8:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to 12/31 1945 and that I last saw h.. alive on Dec. 31 1945

Immediate cause of death	DURATION
pulm. ovary embolism	2 hrs.
Due to Myocardiopathia	
Congest. of Heart Failure	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Elizabeth Bryson M.D.
M. D. or other

Address: Lonaconing Md. Date signed 1/4/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

11714

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs

Hospital, Institution, or street address where death occurred: 435 Columbia St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 435 Columbia St.

(If rural, give LOCATION)

2.(a) If veteran, name war 2nd World War

3.(a) FULL NAME John Henry Cassen

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 25 1899

8. AGE: Years 46 Months 5 Days 22 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Henry Cassen

13. Birthplace Md

MOTHER 14. Maiden name Caroline Barth

15. Birthplace Md

16. Informant Miss Jacqueline Cassen

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Dec 20 19 45 (Date rec'd by registrar) J. P. Rankin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17th., 19 45 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pierce W. Brown M.D. M. D. or other

Address Cumberland, Maryland Date signed 12-17-45

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11715

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: R.F.D. 2 Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carl Wilbert Catow

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 29, 1940

8. AGE:	Years	Months	Days	If less than one day
	5	6	18	..... hrs. ..... min.

9. Birthplace R.D.2, Frostburg Garrett Cty, Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Simon Catow

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Minnie McKenzie

15. Birthplace Maryland

16. Informant Simon Catow

Address R.F.D. 2, Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20-45 (month) (day) (year)

Cemetery or crematory Greenville

Location Greenville Pa.

18. Funeral director J. J. Durst

Address Frostburg Md

19. 12-20 1945 Mrs. Nickey N. Rae

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Dec 17 1945

and that I last saw him alive on Dec 17 1945

Immediate cause of death	DURATION
Streptococcic Endocarditis	2 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. McLane M.D.

M. D. or other

Address Frostburg Md Date signed Dec 19 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 461

CERTIFICATE OF DEATH

11716

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 501 COLUMBIA ST

(If rural, gives LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
MR. STANTON CHESHIRE

3. (b) Social Security Number
705-07-9716

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MYRTLE SHOEMAKER

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) OCT. 13, 1891

8. AGE:	Years	Months	Days	If less than one day
54	54	1	23	hrs. min.

54

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation YARD HELPER B&O R.R. CO.

11. Industry or business

FATHER
12. Name PERRY J. CHESHIRE
13. Birthplace Hampshire Co., W. Va.

MOTHER
14. Maiden name ANNIE GRAPES
15. Birthplace MARYLAND

16. Informant MRS. S.L. CHESHIRE
Address 501 COLUMBIA ST., CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Dec. 9 19 45 (Date rec'd by registrar) Jacob A. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 6, 1945 at 1;30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26 19 45, to Dec. 6 19 45

and that I last saw h... alive on December 6 19 45

Immediate cause of death	DURATION
Carcinoma of the Rectum	
with metastasis	10-10-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson M.D.
M. D. or other

Address [illegible] Date signed 12/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

DR. SNYDER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11717

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA, County MINERAL
City or town RIDGELEY
(If outside city or town limits, write RURAL and give nearest town)
Street No. 135 Main ST.
(If rural, give LOCATION)
2.(a) If veteran, name war U.S.2 MARINES

3. (a) FULL NAME CHARLES R. CLARK

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JUNE 9, 1913

8. AGE: Years	Months	Days	If less than one day
32	5	23	..... hrs. ..... min.

9. Birthplace W, VA.
(Town, county, and state)
10. Usual occupation U.S. MARINES
11. Industry or business

FATHER
12. Name WILLIAM F. CLARK
13. Birthplace MD.

MOTHER
14. Maiden name ELSIE DUCKWORTH
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/5/45 (month) (day) (year)
Cemetery or crematory Hill Crest Cemetery
Location Cumberland, Md.
18. Funeral director William H. Kight
Address Cumberland, Md.

19. Dec. 4 1945 (Date rec'd by registrar) Jos. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 2 1945 at 6:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29, 1945, to Dec. 2, 1945 and that I last saw h alive on Dec. 1, 1945

	DURATION
Immediate cause of death Lobar Pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. J. W. Snyder M. D. or other
Address Cumberland Md. Date signed 12-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (88-a)

11718

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 308 Pulaski Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Mary E. Condon

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: William Condon

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1896

8. AGE: Years	Months	Days	If less than one day
49	9	21	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business: Private duty

FATHER — 12. Name: Joseph Beck

13. Birthplace: Cash Valley, Md.

MOTHER — 14. Maiden name: Anna Martz

15. Birthplace: Cresaptown, Md.

16. Informant: William Condon

Address: 308 Pulaski St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18, 1945 (month) (day) (year)

Cemetery or crematory: Sts. Peter & Paul

Location: Cumberland, Md.

18. Funeral director: John L. Hofer

Address: Cumberland, Md.

19. Dec 18, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 19 45 at 9:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 19 45 to Dec 15 19 45

and that I last saw h[illegible] alive on Dec 15 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	4 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. H. Trevaskis M.D. M. D. or other

Address: Cumberland, Md. Date signed: Dec 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11719

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Mill St.
(If rural, give LOCATION)

2.(a) If veteran, name war World War 2

3.(a) FULL NAME Bernard W. Conley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Ruth Filsinger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7th., 1907

8. AGE: Years 38 | Months 5 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Hoffman, Allegany, Md. (Town, county, and state)

10. Usual occupation Silk Worker

11. Industry or business Celanese Corp.

FATHER
12. Name John Thos. Conley
13. Birthplace Lonaconing, Md.

MOTHER
14. Maiden name Agnes R. O'Connor
15. Birthplace Eckhart Mines, Md.

16. Informant Richard F. Conley
Address 14 Mill St., Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof I-3-1946 (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Kafer

Address Frostburg, Md.

19. 1-2 (Date rec'd by registrar) 1946 Mrs. Nancy H. Dye Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH December 31st., 1945 at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Pierce H. Dorsey, M.D. M. D. or other

Address Cumberland, Maryland Date signed 12-31-45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

DR. WILLIAMS

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

11720

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 days

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or Institution 48 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town ECKHART MINES (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY E. CONNOR

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife JOHN CONNOR

6.(c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) APRIL 11, 1863

8. AGE:

Years	Months	Days	If less than one day
82	7	22	hrs. min

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name WILLIAM ANDERSON

13. Birthplace MARYLAND

MOTHER 14. Maiden name MARIE PORTER

15. Birthplace MARYLAND

16. Informant Memorial Hosp. Address Cumberland, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1945 (month) (day) (year)

Cemetery or crematory Eckhart Cem.

Location Eckhart, Md.

18. Funeral director J. J. DURST

Address FROSTBURG, MARYLAND

19 Dec 5 1945 Jos. L. Franklin, M Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 3, 1945, at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-16-1945 to 12-3-1945 and that I last saw h[illegible] alive on 12-3-1945

Immediate cause of death	DURATION
(a) Generalized Carcinomatosis of Pleura	
Due to (b) Carcinoma of Lung	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or Other

Address Cumberland Date signed 12-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

11721

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 Henry St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Paulette Mae Crabtree

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 1, 1945

8. AGE:

Years	Months	Days	If less than one day
0	0	3	..... hrs. ..... min.

9. Birthplace: Cumberland Allegany-Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Harold Floyed Crabtree

13. Birthplace: Cumberland, Maryland

MOTHER

14. Maiden name: Violet Belle Ammons

15. Birthplace: Clarksburg, W. Va.

18. Informant: Harold Crabtree

Address: 111 Henry St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5, 1945 (month) (day) (year)

Cemetery or crematory: Davis Memorial

Location: Cumberland, Md.

18. Funeral director: John J. Haley

Address: Cumberland, Md.

19. Dec. 5, 1945 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 1945 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1st 1945 to Dec 4 1945 and that I last saw her alive on Dec 3 1945

Immediate cause of death	DURATION
Pulmonary Edema	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A Keyler M. D. or other

Address: 122 Bedford St. Date signed: 12/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

11728

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? x 5 yrs

Hospital, Institution, or street address where death occurred: 401 Pennsylvania Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or towo limits, write RURAL and give nearest town)

Street No. 401 Pennsylvania Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James I. Cramer

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Cora Bowles

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21 1886

8. AGE: Years	Months	Days	If less than one day
59	4	4	hrs. min.

9. Birthplace: Hagerstown Md. (Town, county, and state)

10. Usual occupation: Grocer

11. Industry or business

FATHER 12. Name: Charles Cramer

13. Birthplace: Md.

MOTHER 14. Maiden name: Unknown

15. Birthplace:

16. Informant: John E Bowles

Address: Rt 2 - Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/19/1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemet.

Location: Hagerstown Md.

18. Funeral director: Louis Stein Jr.

Address: Cumberland Md.

19. Dec. 19 1945 (Date rec'd by registrar) Jos. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 1945 at 1 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 25 1943 to 12. 17 1945

and that I last saw him alive on 12. 14. 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Bronchopneumonia	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of operation: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 12/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1625)

CERTIFICATE OF DEATH

11723

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
R.D.#5 Allegany Grove
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D.#5 Allegany Grove
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Crist

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel Crist
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Mar. 17, 1855

8. AGE: Years	Months	Days	If less than one day
90	8	26	hrs. ..... min.

9. Birthplace: Harpers Ferry, W. Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George House
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Jane McFarland
15. Birthplace: W. Va.

16. Informant: Mr. George Martz
Address: R.D.#5 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Dec 15 1945 (Date rec'd by registrar) Jos. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13, 1945, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945 to Dec. 12 1945
and that I last saw h.. alive on Dec. 12 1945

Immediate cause of death	DURATION
Heart failure	
Due to: Old age	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Elizabeth Sroup M.D.
M. D. or Coroner
Address: Sroup, Md. Date signed: 12/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (139-A)

CERTIFICATE OF DEATH

11724 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: La Vale (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Eliza Jane Dawn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Dawn

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 27, 1870

8. AGE:

Years	Months	Days	If less than one day
75	9	15	hrs. min.

9. Birthplace: Mansfield-Grant-W. Va. (Town, county, and state)

10. Usual occupation: Farm - Work

11. Industry or business: Own - home

FATHER 12. Name: Henry Jones

FATHER 13. Birthplace: not known

MOTHER 14. Maiden name: Anna Miller

MOTHER 15. Birthplace: not known

16. Informant: Mrs. Wayne Clavin

Address: Luke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 15, 1945 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: Ellsworth E. Boal

Address: Westernport, Md.

19. 12-13 (Date rec'd by Registrar) 1945 Mrs Nancy H Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12 1945, at 12:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1945, to Dec 12 1945, and that I last saw her alive on Dec 11 1945.

	DURATION
Immediate cause of death: acute Cardiac Dilatation	Sudden
Due to: Hypertension	Several years
Due to:	
Other conditions: acute Pyelitis	1 week

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. Gano M.D. M. D. or other

Address: Frostburg Md. Date signed: 12-12-45

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

11725

2411 N. Charles St., Baltimore 30-2

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address (if not in hospital) where death occurred: Memorial Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 418 Pine Ave

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Leota Davis (Mrs.)

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Wilbur Davis

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Feb 7 1916

8. AGE: Years	Months	Days	If less than one day
29	10	13	..... hrs. ..... min.

9. Birthplace Piedmont W. Va. (Town, county, and state)

10. Usual occupation Elevator operator

11. Industry or business dept Store

FATHER 12. Name Daniel N. Redmond

13. Birthplace W. Va.

MOTHER 14. Maiden name Henrietta Walker

15. Birthplace Ohio

16. Informant Ann Banks.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 18 45 (month) (day) (year)

Cemetery or crematory Woodlawn Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc

Address Cumberland

19. Dec 18 1945 (Date rec'd by registrar) Jas P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1945 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-3- 1945 to 12-15- 1945

and that I last saw h.. alive on 12-13- 1945

Immediate cause of death	DURATION
Chronic nephritis with hypertension	2-3 yrs.
Due to	
Due to	
Other conditions Syphilis, myocardial degeneration.	

(Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard L. Nolan M. D. or other

Address Cumberland, Md. Date signed 12-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits of town

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17a)

CERTIFICATE OF DEATH

11726

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL Hospital

How long in hospital or institution? 19 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County GARRETT

City or town MT. LAKE PARK
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JOHN W. DORN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 28, 1867

8. AGE: Years	Months	Days	If less than one day
78	10	3	hrs. min.

9. Birthplace PA.
(Town, county, and state)

10. Usual occupation UNABLE TO WORK

11. Industry or business

FATHER — 12. Name WILLIAM DORN
13. Birthplace GERMANY

MOTHER — 14. Maiden name EVE RADER
15. Birthplace PA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Jan 4 1946 (month) (day) (year)

Cemetery or crematory Maryland Cemetery

Location Maryland Avenue Md.

18. Funeral director H. C. Leighton

Address Oakland Md.

19. Dec 31, 1945 J. P. Franklin M. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 31 19 45 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-12- 19 45 to 12-31- 19 45

and that I last saw h... alive on 12-31-45 19

Immediate cause of death I M — DURATION

Arteriosclerosis with mesenteric apoplexy and mesenteric hemorrhage

Due to

Due to

Other conditions Benign hypertrophy prostate.
(Include pregnancy within 3 months of death)

Major findings of operation Prostatic resection Date of op. 12-17-45

Autopsy results 12-31-45

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank L. Gleason M.D.
M. D. or other

Address Cumberland Md. Date signed 12-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

11727

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 504 Bedford St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Robert Earsom

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary McClellan

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): June 6, 1873

8. AGE: Years	Months	Days	If less than one day
72	5	29	...hrs. ...min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Miscellaneous

FATHER — 12. Name: William Earsom

FATHER — 13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Mary Neff

MOTHER — 15. Birthplace: W. Va.

16. Informant: Mrs. Wm. Burnett

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 7, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md

18. Funeral director: John F. Hofer

Address: Cumberland, Md.

19. Dec. 7 1945 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1945, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2 1945 to Dec 5 1945 and that I last saw alive on Dec 5 1945

Immediate cause of death	DURATION
Secondary Anemia	
Due to Carcinoma of pancreas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: A. E. Blanchard M. D. or other

Address: ...Date signed 12/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11728

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Nov 29 - to Dec 2 - 45

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of motber)

State Md County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. Mary St - Extended (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wm. Nelson Fadley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Clara Brady 8.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) August 4, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	3	28	....hrs. ....min.

9. Birthplace Columbia Furnace Shenandoah Co. Va (Town, county, and atate)

10. Usual occupation Farmer

11. Industry or business General Farming

FATHER 12. Name Abraham Fadley

13. Birthplace Va.

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Leonard Williams

Address 36 Roberts St Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4, 1945 (month) (day) (year)

Cemetery or crematory Fort Ashby Cemetery

Location Fort Ashby W. Va

18. Funeral director John J Hafer

Address Cumberland Md.

19. Dec. 4 1945 (Date rec'd by registrar) Jos. F. Franklin M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH December 2nd., 1945 at 2.05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Traumatic Shock	
(probably fractured skull)	3 days
Due to	1 hr.,
	35 min.
Due to	
Other conditions Comminuted frac. left leg, middle third. (Includa pregnancy within 3 months of death)	

Major findings of operatinns no operaion ....Date of op....

Autopsy results no autopsy

PHYSICIAN: Please underline the canse tn which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide under investigation Date of 11-29-45

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) street

Means of injury struck by car Injured at work? no

23. SIGNATURE Prince H. Brown M.D. M. D. or other

Address Cumberland, Maryland, Date signed 12-2-45

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 11729 Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 831 Columbia Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 831 Columbia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Fatkin

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sara Woon Fatkin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 9, 1885

8. AGE:	Years	Months	Days	If less than one day
	60	4	16	hrs. min.

9. Birthplace: Vale Summit, Md.
(Town, county, and state)
10. Usual occupation: Postal Clerk
11. Industry or business: U.S. Post Office Dept.
FATHER 12. Name: William Fatkin
13. Birthplace: Maryland
MOTHER 14. Maiden name: Betty Long
15. Birthplace: Penna.
16. Informant: Mrs. Sara Fatkin
Address: 831 Columbia Ave. Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 29, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19. Dec. 28, 1945 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27th, 1945, at 4 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 0---
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Prince H. Johnson, M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 12-27-45

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11730

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 212 N. Lee St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Peter Vincent Firlie

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widdowed

6.(b) Name of husband or wife: Margaret A. Duggan
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 19, 1872

8. AGE: Years	Months	Days	If less than one day
73	7	29	____ hrs. ____ min.

9. Birthplace: Midland, Allegany, Maryland (Town, county, and State)
10. Usual occupation: Manager
11. Industry or business: Savoy Bowling Alleys

FATHER
12. Name: Henry Firlie
13. Birthplace: Holland

MOTHER
14. Maiden name: Margaret Phillips
15. Birthplace: Scotland

16. Informant: Vincent Firlie
Address: 448 Baltimore Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 22, 1945 (month) (day) (year)
Cemetery or crematory: St. Peters & Paul Cemetary
Location: Cumberland, Md.

18. Funeral director: John J. Hafer
Address: Cumberland, Md.

19. Dec. 21 19 45 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18th 19 45 at 5:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-16-45 19 to 12-18-45 19 and that I last saw h Rem alive on 12-18-45 19

Immediate cause of death	DURATION
Carcinoma Stomach	1 yr.
Due to	
Due to	
Other conditions: Intestinal Hemorrhage	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. C. Zimmerman M. D. or other
Address: Cumberland Md. Date signed: 12-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

11731

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos & 6 mos 11 days
Hospital, Institution, or street address where death occurred: Big Vein Hill
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)
Street No.: Big Vein Hill (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Matthew Fitzpatrick

3.(b) Social Security Number: 220-10-2191

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): June 3, 1879
8. AGE: Years: 67 Months: 6 Days: 11 If less than one day: hrs. min.
9. Birthplace: Lonaconing Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Coal Miner — Retired
11. Industry or business: Coal Mines
FATHER 12. Name: Michael Fitzpatrick
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Nora Mahoney
MOTHER 15. Birthplace: Nova Scotia
16. Informant: Miss Nora McGregor
Address: Lonaconing Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 17 1945 (month) (day) (year)
Cemetery or crematory: St. Marys Cemetery
Location: Lonaconing Md
18. Funeral director: Mr. Eichhorn
Address: Lonaconing, Md
19. DEC 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1945 at 12:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to Dec 14th 1945
and that I last saw h[illegible] alive on Dec 12 1945

Immediate cause of death — DURATION
Chronic Nephritis - Uraemia
Chronic Bronchitis - Asthma
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other
Address: Lonaconing, Md Date signed: Dec 16th 45

Corson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11732

Reg. Dist. No. 2

1. PLACE OF DEATH:
County Allegany
City or town Flintstone
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Flintstone
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Flintstone
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Larry Hodges Fletcher

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Child.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1941

8. AGE:

Years	Months	Days	If less than one day
4	7	26	hrs. min.

9. Birthplace Cumberland Allegany Co, Md.
(Town, county and state)
10. Usual occupation Child.
11. Industry or business

FATHER
12. Name Roy S. Fletcher
13. Birthplace Flintstone Md.

MOTHER
14. Maiden name Mattie Whorton
15. Birthplace Dawson Md

16. Informant Roy S Fletcher
Address Flintstone Md.

17. Burial Date thereof Dec. 18 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Brethren Cemetery
Location Flintstone, Md.
18. Funeral director John J. Hafer.
Address

19. Dec 18 1945 Nina L. Bender
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1945, at about 10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19, to 19
and that I last saw h alive on 19

Immediate cause of death Accidental gunshot wound — DURATION killed instantly
Due to (.30-30 rifle bullet)
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations ---
Date of op.
Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 12-16-45
Where did injury occur? near Flintstone, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury gunshot Injured at work? no

23. SIGNATURE Pierce K. Bowers, M.D.
M. D. or other
Address Cumberland, Maryland Date signed 12-17-4

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

11733

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Allegany Hospital
County
City or town: Allegany Co (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 M
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 16 M

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No. 435 N. Centre St. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harman.U.F.Flurshutz

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Wid

6.(b) Name of husband or wife: Margaret Flurshutz
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 17 1854

8. AGE: Years	Months	Days	If less than one day
91	11		..... hrs. ..... min.

9. Birthplace: Maryland Cumberland Md (Town, county, and state)
10. Usual occupation: ~~Furniture~~ Merchant
11. Industry or business: Furniture Co.
FATHER 12. Name: George J.Flurshutz
13. Birthplace: Germany
MOTHER 14. Maiden name: Sopha.Ebert
15. Birthplace: Germany
16. Informant: Fred Flurshutz
Address: 413.N.Mechanic St Cumberland Md
17. Burial (Burial, cremation, or removal) Date thereof 11 20.1945 (month) (day) (year)
German Luthran.
Cemetery or crematory
Location: Cumberland Md
18. Funeral director: John.C.Wolford
Address: Cumberland Md
19. Dec. 19 1945 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945 at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 30 1944 to Dec 17 1945 and that I last saw him alive on Dec 17 1945

Immediate cause of death	DURATION
Influenza	
Due to	
Due to	
Other conditions Old fractures left Leg	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R M Weakley M. D. or other
Address 4 & Greene St Date signed 12-18-45

Within corporate limits

Evidence for the change of the year of birth of the deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. I 00 JAN 8 1946

CERTIFICATE OF DEATH

11734

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Park St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter A Fraley Sr.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Viola L. Gerdeman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 1 1873 1883

8. AGE: Years 67 Months 11 Days 16 If less than one day ..... hrs. ..... min.

9. Birthplace Terra Alta W. Va. (Town, county, and state)

10. Usual occupation Yard Conductor (Retired)

11. Industry or business B & O Ry.

FATHER 12. Name Geo W. Fraley

FATHER 13. Birthplace W. Va.

MOTHER 14. Maiden name Sarah Deety

MOTHER 15. Birthplace W. Va.

16. Informant Mrs Viola G. Fraley

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/20/45 (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem

Location Cumberland

18. Funeral director Louis Stein Sons

Address Cumberland

19. Dec. 20, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941 19.. to 12-17-45 19..

and that I last saw him alive on 12-16-45 19..

Immediate cause of death	DURATION
Diabetes Mellitus	4 yrs
Due to	
Due to	
Other conditions cirrhosis of liver	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. B. Gerdeman M. D. or other

Address Cumberland, Md. Date signed 12-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

11735

★ Reg. Diat. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residance of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Vine St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Leroy Frankland

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amanda Fausnaught Frankland

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 8, 1871

8. AGE: Years	Months	Days	If less than one day
74	4	0	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Retired Carpenter

11. Industry or business

FATHER 12. Name: Harry Frankland

FATHER 13. Birthplace: Don't know

MOTHER 14. Maiden name: Don't know

MOTHER 15. Birthplace: " "

16. Informant: Mrs. Amanda Frankland

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11, 1945 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md

18. Funeral director: Wm. Harold Friedlob Jr.

Address: Piedmont, W.Va.

19. Dec. 10 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 19 45 at 11 P M

I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 45 to Dec 8 19 45

and that I last saw h.. alive on December 8, 19 45

Immediate cause of death	DURATION
Diabetes Mellitus	
Due to	
Due to	
Other conditions	

(Include preguancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P E Berry M.D. M. D. or other

Address: Piedmont W.Va. Date signed: 12-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11736

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred: 822 Buckingham Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 822 Buckingham Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Otto Frey

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Emma Regina Frey
8.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): June 16 - 1874

8. AGE: Years: 71 Months: 6 Days: 13 If less than one day: 5 hrs. 30 min.

9. Birthplace: Pittsburgh, Pa. (Town, county, and state)
10. Usual occupation: Builders Supply
11. Industry or business: Retired

FATHER
12. Name: Otto Frey
13. Birthplace: Germany

MOTHER
14. Maiden name: Constance Herring Frey
15. Birthplace: Germany

16. Informant: J. Russell Cook
Address: 822 Buckingham Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 1-1946 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Allegany County, Cumberland, Md.

18. Funeral director: J. J. Gurst
Address: Frostburg

19. Jan. 1 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-29-1945 at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945 to 12-29-1945
and that I last saw him alive on 12-28-1945

Immediate cause of death	DURATION
Carcinoma of Pancreas	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of Pancreas Date of op. April 45
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 12-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

11737

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? ½ Hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Windsor Hotel- Baltimore St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles W. Fries

3.(b) Social Security Number: 5

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Agnes Grant Fries
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 13, 1872

8. AGE: Years	Months	Days	If less than one day
73	8	20	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: Retired Clerk
11. Industry or business: B.& O. R.R. Co.
FATHER 12. Name: Jacob Fries
13. Birthplace: Germany
MOTHER 14. Maiden name: Margaret E. Boore
15. Birthplace: Germany
16. Informant: Mrs. Agnes Fries
Address: Windsor Hotel Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.
19 Dec. 6 1945 Jos. L. Franklin M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3, 1945, at 10:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3, 1945, to Dec 3 1945
and that I last saw h— alive on Dec 3 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 hrs
Due to: Cardia Vascular Disease — 3 yrs
Due to: Hypertension — 3 yrs
Other conditions: Chronic Nephritis
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos M Fraser M. D. or other
Address: Cumberland Md Date signed 12-3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11738

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: GARRETT
City or town: MT. LAKE PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JAMES GARRETT

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 5, 1869

8. AGE:

Years	Months	Days	If less than one day
76	4	12	..... hrs. ..... min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: FARMER

11. Industry or business

FATHER
12. Name: Patrick Garrett
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Sheridan
15. Birthplace: Ireland

16. Informant: Emroy Bolden
Address: Oakland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20 1945 (month) (day) (year)
Cemetery or crematory: Oakland
Location: Oakland

18. Funeral director: Emroy Bolden
Address: Oakland Md

19. Dec. 20, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 17 1945 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12.17.45 to 12.17.45 and that I last saw him alive on 12.17.45

Immediate cause of death: Bronchopneumonia — DURATION: 3 days
Due to: Hemiplegia right side (Cerebral Thrombosis).
Other conditions:
(Incinde pregnancy within 3 months of death)
Major findings of operations: None
Date of op None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 12-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-4)

CERTIFICATE OF DEATH

11739

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 238 Humbird St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Cleveland Graham

3. (b) Social Security Number: 217-10-6545

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1883

8. AGE:

Years	Months	Days	If less than one day
62	-		..... hrs. ..... min.

9. Birthplace: W. Va. (Town, county, and state)

10. Usual occupation: Loader

11. Industry or business: B & O Ice Plant

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace

16. Informant: Paul Freeland

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/10/45 (month) (day) (year)

Cemetery or crematory: St. Peter & Pauls Cem

Location: Cumberland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland

19. Dec. 10 1945 (Date rec'd by registrar) Joseph F. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 7 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 28 1945, to 12-7-1945 and that I last saw him alive on 12-7-1945

Immediate cause of death: Chronic Myocarditis Degeneration. Pulmonary Obstruction. — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Osteosarcoma dextral ulna Date of op. Dec 1-45

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. F. Williams M.D. or other

Address: Cumberland Date signed: 12-8-45

Williams -

Dr. Diehl

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 117419

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Miners Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 172 Oakland
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wm Fredrick Griffith

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Katherine Griffith

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Sept. 19 - 1870

8. AGE: Years 75 | Months 3 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace: Frostburg Allg. Md.
(Town, county, and state)

10. Usual occupation: retired

11. Industry or business: coal Miner

FATHER — 12. Name: Wm Griffith

13. Birthplace: Frostburg, Md

MOTHER — 14. Maiden name: Jane Morris

15. Birthplace: Frostburg, Md

16. Informant: Mrs Hugh Duggan

Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3 1946 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Dunn

Address: Frostburg, Md.

19. 1-3 (Date rec'd by registrar) 19 46 Wm Lawrence Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 19 45 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 19 45, to Dec. 31 19 45 and that I last saw him alive on Dec. 31 19 45

Immediate cause of death	DURATION
arterio-sclerotic cardio-vascular disease	several years
Due to: Bronchial asthma	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: X ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: H. C. Diehl, M. D.
M. D. or other

Address: Frostburg, Md. Date signed 1-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11742

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 130 Humbird St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Helen Evelyn Groves

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Child

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 3, 1942

8. AGE:

Years	Months	Days	If less than one day
3	1	2	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co. Md (Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER

12. Name: Chas. Howard Groves

13. Birthplace: Cumberland, Md.

MOTHER

14. Maiden name: Eva Dugham

15. Birthplace: Harpers Ferry W. Va.

16. Informant: Chas. H. Groves

Address: 130 Humbird St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 8, 1945 (month) (day) (year)

Cemetery or crematory: Mt Herman Cemetery

Location: Near Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec 8 1945 (Date rec'd by registrar) Joseph C. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1945 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5 1945 to December 5 1945 and that I last saw her alive on December 5 1945

Immediate cause of death	DURATION
Influenza	3 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Cumberland, Md Date signed: 12-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

11743

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, Institution, or street address where death occurred: 515 Rose Hill Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 515 Rose Hill Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Rosa "Haberlein" Hadra

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Edward Hadra

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Oct 21, 1870

8. AGE:

Years	Months	Days	If less than one day
75	2	10	...hrs. ...min.

9. Birthplace: Frostburg Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER

12. Name: Henry Haberlein

13. Birthplace: Germany

MOTHER

14. Maiden name: Mary Knotz

15. Birthplace: Germany

16. Informant: Edward H. Hadra

Address: West Palm Beach, Fla.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3, 1946 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md

18. Funeral director: John F. Hafer

Address: Cumberland Md.

19. Jan 3 1946 (Date rec'd by registrar) Joseph C. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12. 20. 1945, to 12. 31, 1945 and that I last saw h[illegible] alive on 12. 20. 1945

Immediate cause of death: Chronic Hypocardial Degeneration

DURATION: ?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 1-3-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

117449
Reg. Dist. No.

McLane

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 72 Mt Pleasant
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edwin John Harvey

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Clara Harvey
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19-1862

8. AGE: Years 83 | Months 3 | Days 6 | If less than one day ... hrs. ... min.

9. Birthplace St Day Cornwell England
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Florist

FATHER 12. Name Edwin John Harvey
13. Birthplace St Day Cornwell, England

MOTHER 14. Maiden name Esther Jane Read
15. Birthplace St. Day Cornwell, England

16. Informant Albert Harvey
Address Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 27-1945 (month) (day) (year)

Cemetery or crematory Allegany
Location Frostburg, Md

18. Funeral director J. J. Dent
Address Frostburg, Md

19. 12-26-45 Wm. Lavey R.Reg.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1945 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1938 19 to Dec 27 1945
and that I last saw him alive on Dec 11 1945

Immediate cause of death	DURATION
Arterio-Sclerosis	Many years
Due to	
Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. O. McLane Jr M.D.
M. D. or other
Address Frostburg Md Date signed 12-26-45

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11745

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 317 Pulaski St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 317 Pulaski St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Gertrude Holzer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ———
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 21 1870

8. AGE: Years	Months	Days	If less than one day
75	3	0	..... hrs. ..... min.

9. Birthplace: Cumberland md
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home

FATHER
12. Name: John Holzer
13. Birthplace: md

MOTHER
14. Maiden name: Katherine Paulin
15. Birthplace: md

16. Informant: Frank Holzer
Address: Cumberland md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24 45 (month) (day) (year)
Cemetery or crematory: St. P. & P. Cem.
Location: Cumberland md

18. Funeral director: Louis Thos Lee
Address: Cumberland md

19. Dec. 24, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 21 1945, at 4 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1945, to Dec 21 1945
and that I last saw her alive on Dec 20 1945

	DURATION
Immediate cause of death: Coronary Occlusion	Instant
Due to: Organic Heart Condition	yrs
Due to: Arteriosclerosis	yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Thos A Lee
Address: Cumberland Md
M. D. or other
Date signed: 4 8 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-a

CERTIFICATE OF DEATH

11746

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A 15

1. PLACE OF DEATH:

County Allegany / Cumberland

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred: 733 Hilltop Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Pennsylvania County Bedford

City or town Hyndman Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jennie Catherine Hosselrode

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Herman Hosselrode

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 16, 1860

8. AGE: Years	Months	Days	If less than one day
85	1	29	..... hrs. ..... min.

9. Birthplace New Buena Vista, Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

MOTHER FATHER

12. Name Jacob Teichtner

13. Birthplace Hyndman, Pa

14. Maiden name Anna Cook

15. Birthplace Hyndman, Pa.

16. Informant Mrs. Perry Clark

Address Hyndman, Pa R.D. 1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 8 1945 (month) (day) (year)

Cemetery ~~& crematory~~ Palo Alto

Location Hyndman Rural

16. Funeral director W. H. Leasher

Address Hyndman, Pa.

19. Dec. 7, 1945 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 19 45 at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 19 45 to 12/5 19 45

and that I last saw h... alive on 12/3 19 45

Immediate cause of death	DURATION
apoplexia cerebri	
Due to arterial hypertension	
Due to	
Other conditions pernicious anemia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elizabeth Briggs, M.D. M. D. or other

Address Long Gap Date signed 12/6

Within corporate limits Clarion

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

11747

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs.

Hospital, institution, or street address where death occurred:

10 Harrison St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Harrison St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Mona Arminta Hottinger

3.(b) Social Security Number 220-10-1994

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife Wm J. Hottinger

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 31, 1897

8. AGE:

Years	Months	Days	If less than one day
48	1	27	..... hrs. ..... min.

9. Birthplace Buckhannon, Randolph Co. W. Va

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER 12. Name George Cunningham

13. Birthplace Buckhannon W. Va

MOTHER 14. Maiden name Margaret Mc Kizzic

15. Birthplace Buckhannon W. Va.

16. Informant Wm J. Hottinger

Address 10 Harrison St - Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31, 1945 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Dec. 31 1945 J. P. Franklin, M. D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1945 to Dec. 28 1945

and that I last saw h... alive on Dec. 28 1945

Immediate cause of death Acute Pancreatitis — DURATION 4 hrs.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operation .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A. H. Gleason M. D. or other

Address 126 West N Cumberland Md. Date signed 12-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11748

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18. Years

Hospital, institution, or street address where death occurred:
709. Frederick St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 709. Frederick St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Peter Houck

3.(b) Social Security Number: 705-05-8084

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mildred G. Houck

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.): June 4 1890

8. AGE: Years	Months	Days	If less than one day
55	6	4	...hrs. ...min.

9. Birthplace: Harrisburg, Pa
(Town, county, and state)

10. Usual occupation: Telegrapher

11. Industry or business: Baltimore & Ohio Railroad

FATHER
12. Name: John T. Houck
13. Birthplace: Hedgesville, W. Va.

MOTHER
14. Maiden name: Katherine Hoover
15. Birthplace: Harrisburg, Pa.

16. Informant: Mrs. Charles P Houck
Address: 709. Frederick St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/11/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec. 10 19 45 (Date rec'd by registrar) Joseph C. Feagley M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1945, at 5-20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8 19.. to ..19..

and that I last saw h.. alive on ..19..

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Organic Heart Disease	6 Mo
Due to: only complained about 10 minutes before death	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos A Houck M. D. or other

Address: Cumberland Md Date signed 12-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

11749

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 yrs.

Hospital, Institution, or street address where death occurred: 430 Homer St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 430 Homer St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: G. Blaine Hoyle.

3.(b) Social Security Number: 705-07-9554

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Fannie Squires

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 24, 1886

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
59	6	15		

9. Birthplace: Berkley Springs W. Va.
(Town, county, and state)

10. Usual occupation: Baksman

11. Industry or business: B & O Ry.

FATHER — 12. Name: John Hoyle

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Jennie Miller

15. Birthplace: W. Va.

16. Informant: Mrs G. Blaine Hoyle

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/12/45 (month) (day) (year)

Cemetery or crematory: Greenmount Cem

Location: Cumberland

18. Funeral director: Louis Steiss Inc

Address: Cumberland

19. Dec. 12 1945 (Date rec'd by registrar) Jos C. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9 1945, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan, 1945 to Dec. 9 1945 and that I last saw h alive on Dec 8 1945.

Immediate cause of death	DURATION
Pulmonary Carcinoma	12 Mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Emerick M. D. or other

Address: 26 Queen St Cumberland Md Date signed: 12/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11750

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

567 Fort Hill Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 567 Fort Hill Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Adeline George Hyde

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Walter C. Hyde

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): July 26, 1879

8. AGE: Years	Months	Days	If less than one day
66	4	19	...hrs. ...min.

9. Birthplace: Fairview, Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER 12. Name: George Stuckey

13. Birthplace: Pa.

MOTHER 14. Maiden name: Susan Miller

15. Birthplace: Pa.

16. Informant: Mark Hyde

Address: Bowling Green - R.F.D. - Cumb.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 18, 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Dec 18, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1945, at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3 1945, to December 15 1945, and that I last saw h[illegible] alive on December 14 1945.

	DURATION
Immediate cause of death: Congestive heart failure	[illegible] months
Due to: Chronic myocarditis	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other

Address: [illegible] Date signed 12-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11751 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:
519 Pine Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 519 Pine Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Amos Steward Hymes

3.(b) Social Security Number: 217-10-7058

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife: Helen Renlow

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): April 25, 1904

8. AGE:	Years	Months	Days	If less than one day
	41	7	17	...hrs. ...min.

9. Birthplace: Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation: Twisting Dept

11. Industry or business: Celanese

FATHER
12. Name: George P. Hymes
13. Birthplace: Bedford Co., Pa.

MOTHER
14. Maiden name: Nancy S. Hymes
15. Birthplace: Artemas, Pa.

16. Informant: William M. Hymes
Address: Cumberland, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: December 14, 1945
(month) (day) (year)

Cemetery or crematory: Mt. Hope Christian Cemetery

Location: 4 mi. North at East Side of Polish Mt.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Dec. 14 1945
(Date rec'd by registrar)

J. P. Hamblin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17, 1945, at 3:45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 45, to Dec 19 45, and that I last saw h... alive on ... 19...

Immediate cause of death: Primary Metastatic Sarcoma

DURATION
about 1 yr

Due to: Sarcoma of neck

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: NO

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. K. Owens M. D. or other

Address: 133 Va Ave Date signed: 12/14/45

Outside of City Limits

11752

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Allegany

City or town: ~~Bar~~ Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:
Rt 3 - Bowmans Addt. - Cumberland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt 3, Bowmans Addn
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Della Donaldson Imler

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Glenn Imler

B.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): May 30 1900

8. AGE: Years	Months	Days	If less than one day
45	6	25	...hrs. ...min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Harry Donaldson
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Cora Gaff
15. Birthplace: Deer Park, Md

16. Informant: Glenn Imler

Address: Rt 3, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27, 1945 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec 27 1945 (Date rec'd by registrar) Joseph C. Trenkle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1945 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death: Carcinoma of Left Breast — DURATION: 2 yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: no operation — Date of op.:

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Prince H. Bowman, M.D. (M. D. or other)

Address: Cumberland, Maryland Date signed: 12-27-45

Deputy Medical Examiner - Allegany Co.

Within corporate limits

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

CERTIFICATE OF DEATH

11753

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 19 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PENNA. County BEDFORD

City or town RT. #3, LAKE GORDON
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME MR. GURNEY INGRAM

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARTHA SHIRLEY

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) MARCH 25 1885

8. AGE:	Years	Months	Days	If less than one day
	60	8	23	..... hrs. ..... min.

9. Birthplace MINNESOTA
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER 12. Name JAMES INGRAM

13. Birthplace MINNESOTA

MOTHER 14. Maiden name EUNICE BENHEM

15. Birthplace MINNESOTA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22 45 (month) (day) (year)

Cemetery or crematory St. Peter & Pauls Cem

Location Cumberland

16. Funeral director Louis Stein Inc

Address Cumberland

19. Dec. 21, 1945 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 18, 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV. 29, 1945, to DEC. 18 1945 and that I last saw him alive on DEC. 18 1945

Immediate cause of death	DURATION
Carcinoma	
Due to Ca Naso-pharynx.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. F. Williams M. D. or other

Address Cumberland Date signed 12/18/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

11754

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 63 Years

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 146 WINEOW ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
MESS ANNA JOHNSON

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	COLORED	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JUNE 1, 1882

8. AGE: Years	Months	Days	If less than one day
63	6	10	..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWORK

11. Industry or business

FATHER
12. Name ± Louis Tabasso
13. Birthplace MARYLAND Va.

MOTHER
14. Maiden name ELLEN J. ± Able
15. Birthplace MARYLAND Moorefield, W. Va.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial Date thereof Dec. 14, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location Cumberland

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Dec. 14, 19 45 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 11, 19 45 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC. 6, 1945, to DEC. 11, 1945 and that I last saw h... alive on DEC. 11 1945

	DURATION
Immediate cause of death Lobar Pneumonia	Days
Due to	Wks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D. F. Williams M. D. or other

Address Cumberland Date signed 12-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

11755

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Midland Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 14 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Robert Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	7.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 6th 1945

8. AGE:

Years	Months	Days	If less than one day
	2	14	..... hrs. ..... min.

9. Birthplace: Lonaconing, Md

(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: John Robert Jones

13. Birthplace: Scranton Pa.

MOTHER

14. Maiden name: Margaret A. Wriggle

15. Birthplace: Cumberland Md.

16. Informant: Vernell Coleman

Address: Frostburg R.F.D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 20 45 (month) (day) (year)

Cemetery or crematory: Old Coney Cemetery

Location: Lonaconing, Md

16. Funeral director: M. Eichhorn

Address: Lonaconing Md

19. DEC 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20 1945, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hacking & whooping Cough	1 month
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.

M. D. or other

Address: Lonaconing Md Date signed: Dec. 20 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11758

Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69 yrs
Hospital, Institution, or street address where death occurred:
10 Hanecamp St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 10 Hanecamp St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Hayes Jones

3.(b) Social Security Number: 216-07-2733

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Myrtle Jones

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 27, 1877

8. AGE:

Years	Months	Days	If less than one day
68	3	12	hrs. min.

9. Birthplace: Lonaconing-Allegany-Md.
(Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business: Silk-Mill

FATHER
12. Name: Daniel T. Jones
13. Birthplace: Nova, Scotia

MOTHER
14. Maiden name: Jean Kirkwood
15. Birthplace: Eckhart, Md.

16. Informant: Rethia Jones
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 12, 1945 (month) (day) (year)
Cemetery or crematory: M.E. Cemetery
Location: Mt. Savage, Md.

18. Funeral director: Ellsworth S. Boal.
Address: Westernport, Md.

19. DEC 11 1945 (Date rec'd by registrar) Dr. S. Owen Fyfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 9th 1945, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 6th 1945, to Dec 9th 1945 and that I last saw h[illegible] alive on Dec 8th 1945

Immediate cause of death	DURATION
Coronary occlusion	Sudden death
Due to	
Due to	
Other conditions: Chronic Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other
Address: Lonaconing, Md. Date signed: Dec. 11, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

11757

2411 N. Charles St., Baltimore (49-3)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 3 1/2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 705 Stephart Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rita Cecelia Karp

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Max Karp

6.(c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) June 3rd, 1921

8. AGE: Years	Months	Days	If less than one day
24	6	3	..... hrs. ..... min.

9. Birthplace Oil City, Pennsylvania (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Robert Meyer Karn

13. Birthplace Pittsburgh, Pa

MOTHER 14. Maiden name Sadie Rabbbrode

15. Birthplace Poland

16. Informant Ruth Karn - Sister

Address 705 Stephart

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23 1945 (month) (day) (year)

Cemetery or crematory Pittsburgh Cem

Location Pittsburgh Pa.

18. Funeral director Louis Stein Sons

Address Cumberland Md.

19. Dec. 22 1945 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1944, to Dec 21, 1945

and that I last saw her alive on Dec 21, 1945

Immediate cause of death	DURATION
Carcinoma Ovary	1 yr 10 mo
(Papillary adenocarcinoma)	
Due to	
Due to	
Other conditions Metastasis abdomen,	1 yr 10 mo
Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operation Intestinal obstruction because of Malignancy Date of op. 9-16-45

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Elliott Rathbone M.D. M. D. or other

Address Memorial Hospital Date signed 12-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

Foster

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

11758

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:
806 Columbia Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 806 Columbia Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Edgar Kegg

3.(b) Social Security Number 214-05-8135

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Josephine Rohman Kegg

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 18, 1875

8. AGE: Years	Months	Days	If less than one day
70	8	8	...hrs. ...min.

9. Birthplace: Meyersdale, Pa
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Baking Co

FATHER
12. Name: Andrew F. Kegg
13. Birthplace: Rainsburg, Pa

MOTHER
14. Maiden name: Mary A. Suter
15. Birthplace: Springfield, Ohio

16. Informant: John Luther Kegg
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 29 1945 (month) (day) (year)

Cemetery or crematory: Sts. Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec. 29 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1945, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Dec 26 1945

and that I last saw him alive on 12/26 1945

Immediate cause of death: (a) Cardiac Renal	DURATION
Due to: (b)	
Due to: (c)	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. Kegg M. D. or other

Address: 124 Bedford St Date signed: 12/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (637)

CERTIFICATE OF DEATH

★ 11759 Reg. Dist. No. 4

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, Institution, or street address where death occurred: 7 Market St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7 Market St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Bridget Kenney

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife James D Kenney

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 1871

8. AGE: Years 74 | Months 6 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Mc Geeney

13. Birthplace Ireland

MOTHER 14. Maiden name Elizabeth Mc Cartland

15. Birthplace Ireland.

16. Informant James F Kenney

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 16 45 (month) (day) (year)

Cemetery or crematory St Patricks Cem

Location Cumberland

18. Funeral director Louis Stein, Inc.

Address Cumberland

19. Dec. 14, 1945 Jos. P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1945, at 11.45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 23 1945 to Dec. 12 1945 and that I last saw h.. alive on ~~November~~ Dec. 12 1945

Immediate cause of death	DURATION
Arteriosclerosis	3 years
Due to Hyperthyroid Disease	
Due to Unknown	
Other conditions Hypertension,	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elon M. Schindler M.D., M. D. or other

Address 41 Greene St. Date signed Dec. 13/1945

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11760 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-1

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital, Cumberland, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 634 Maryland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Patrick T. Lacey

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Susan Lacey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 4th, 1863

8. AGE: Years	Months	Days	If less than one day
82	8	22	hrs. min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: Retired - Superintendent
11. Industry or business: B&O. R.R. Bolt & Forge Shops

FATHER
12. Name: Patrick Lacey
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary King
15. Birthplace: Ireland

16. Informant: Mrs. Susan Lacey
Address: 634 Maryland Ave. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 28 1945 (month) (day) (year)
Cemetery or crematory: St. Patricks Cem
Location: Cumberland, Md.

18. Funeral director: Chas. L. George
Address: Cumberland, Md.

19. Dec 28, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/26 19 45 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 13 19 45, to Dec 26 19 45
and that I last saw h[illegible] alive on Dec 26 19 45

Immediate cause of death	DURATION
Lobular Pneumonia	10 days
Due to, Chronic Bronchitis	1 Yrs
Due to, Chronic Nephritis	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos. A Kraus M.D.
M. D. or other
Address: Cumberland Md Date signed 12-27

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11761

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Midland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Midland Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Railroad St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Monica Langham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 14 - 1913

8. AGE:

Years	Months	Days	If less than one day
32	0	0	..... hrs. ..... min.

9. Birthplace Midland Allegany Md. (Town, county, and state)

10. Usual occupation Coming Department

11. Industry or business Celanese Corp.

FATHER 12. Name James Langham

13. Birthplace Midland, Md.

MOTHER 14. Maiden name Anna McCutcheon

15. Birthplace Bluefield Va.

16. Informant Mrs. Franklin McElwee

Address Midland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-18-1945 (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg, Md.

18. Funeral director Talbot Davis

Address Frostburg, Md.

19. Dec 18 1945 (Date rec'd by registrar) D. E. Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14th 1945, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945, to Dec 14th 1945 and that I last saw h.. alive on Dec 7 1945

Immediate cause of death	DURATION
Pernicious anaemia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Henry M. Hodgson M.D. M. D. or other

Address Lonaconing, Md. Date signed Dec. 18th 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 11762 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 Years

Hospital, Institution, or street address where death occurred:
6. Decatur St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6. Decatur St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Carl Leon Leonard

3.(b) Social Security Number: 214-05-8618

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Lulu Leonard

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): December 3 1884

8. AGE: Years	Months	Days	If less than one day
61	0	1	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Auditor

11. Industry or business: Cumberland Motor Express

FATHER 12. Name: Thomas A. Leonard

13. Birthplace: Brownsville, Pa

MOTHER 14. Maiden name: Florence Steiner

15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Carl L. Leonard

Address: 6. Decatur St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/7/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec 7 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 1945, at 1-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1945 to Dec 4 1945 and that I last saw him alive on Dec 3 1945

Immediate cause of death	DURATION
Angina Pectoris	1 Year
Due to: Organic Heart Disease	4 Years
Due to: Chronic Nephritis	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Thos. A. Kight M. D. or other

Address: Cumberland, Md. Date signed 12-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (356)

CERTIFICATE OF DEATH

11763

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland 2nd
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 12-9-45
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Hardy
City or town: Moorefield
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Chester Lofton
3.(b) Social Security Number: None

4. Sex: M
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 7, 1935
8. AGE: Years: 10 Months: 8 Days: 11 If less than one day: hrs. min.
9. Birthplace: Moorefield, W. Va. (Town, county, and state)
10. Usual occupation: Student.
11. Industry or business:
FATHER 12. Name: Tomie Lofton
13. Birthplace: W. Va.
MOTHER 14. Maiden name: Sadie Sias
15. Birthplace: W. Va.
16. Informant: Mother
Address: Moorefield, W. Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 22, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cem.
Location: Moorefield, W. Va.
18. Funeral director: P. E. Kreuch
Address: Moorefield, W. Va.
19. Dec 21, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-18-1945 at 8:10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 1945 to Dec. 18 1945 and that I last saw h[illegible] alive on Dec. 18 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to: Rheumatic Heart Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 12/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

11764

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 3 hrs.

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Barton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Baby Boy Sagsdon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1945

8. AGE:

Years	Months	Days	If less than one day
			13 hrs. ..... min.

8. Birthplace: Frostburg-Allegany-Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: James Clement Sagsdon

13. Birthplace: Barton, Md

MOTHER

14. Maiden name: Mary Wanda Dieling

15. Birthplace: Westernport, Md

16. Informant: James Clement Sagsdon

Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 31 1945 (month) (day) (year)

Cemetery or crematory: St. Peters Cemetery

Location: Westernport, Md.

18. Funeral director: Edgar L. & E. Boal

Address: Westernport, Md.

19. 12-30 1945 (Date rec'd by registrar) Mrs. Nancy H. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1945; at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29 1945, to Dec 30 1945

and that I last saw him alive on Dec 29th 1945

Immediate cause of death	DURATION
Congenital Heart defect "Blue baby"	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Norman Reese M.D.

M. D. or other

Address: Westernport, Md. Date signed 12-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

DR. DAUGHERTY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54b)

CERTIFICATE OF DEATH

Reg. Dist. No. 11765 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 427 VIRGINIA AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME DAVID LONG

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	CHILD

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 3 1942

8. AGE: Years	Months	Days	If less than one day
3	4	16	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name OSCAR LONG
13. Birthplace MARYLAND
MOTHER 14. Maiden name DOROTHY KRIEGER
15. Birthplace MARYLAND
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 21 45 (month) (day) (year)
Cemetery or crematory Greenmount Cem.
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland
19 Dec. 21 1945 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 19 1945 at 4:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1945, to Dec 19 1945
and that I last saw h. alive on December 19 1945
Immediate cause of death Glioma of Brain — DURATION 6 mo +
Due to
Due to
Other conditions None
(Include pregnancy within 3 months of death)
Major findings of operations Glioma of Bone
Date of op. Oct 1945
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Leslie E. Daugherty M. D. or other
Address 7 Wash St Cumberland Md Date signed 12-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-e

11766

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred: Mayer's Hospital

How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. 147 Upper Grand St (If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Thomas Joseph Lynch

3.(b) Social Security Number 105-05-4986 Railroad

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma Mauser 6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug. 11 - 1887

8. AGE: Years 58 Months 3 Days 11 If less than one day ____ hrs. ____ min.

9. Birthplace St. Louis Mo. (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business B & O. R. R. Co.

FATHER 12. Name John Lynch

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden name Mary Gardner

MOTHER 15. Birthplace Ireland

16. Informant Paul J. Lynch

Address 147 Upper Grand St. Frostburg Md.

17. Burial, cremation, or removal. Which? Burial Date thereof 12-24-1945 (month) (day) (year)

Cemetery or crematory St Michael's Cem.

Location Frostburg Md.

18. Funeral director Daniel Decker

Address Frostburg, Md.

19. 12-22 1945 (Date rec'd by registrar) Wm. Henry H. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20th, 1945, at 3.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__ and that I last saw h____ alive on ____ 19__

Immediate cause of death	DURATION
Embolism, Coronary	10 min.
Due to	
Due to	
Other conditions Comminuted fractures of both legs. (Include pregnancy within 3 months of death)	

Major findings of operations reduction of fractures. Date of op. ____

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Under investigation Date of 12-19-45

Where did injury occur? Near Eckhart, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury struck by auto Injured at work? no

23. SIGNATURE Prince H. Brown, M.D. M. D. or other

Address Cumberland, Maryland Date signed 12-20-45

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83(a)

CERTIFICATE OF DEATH

11767

Reg. Diat. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: West Main Strat

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.: West Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Walter Mackey

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Agnes Swindle

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): June 23, 1870

8. AGE: Years	Months	Days	If less than one day
75	5	27	...hrs. ...min.

9. Birthplace: Lonaconing Allegany Co. Md
(Town, county, and state)

10. Usual occupation: Coal Mining

11. Industry or business: Georges Creek Coal Co

FATHER
12. Name: James Mackey
13. Birthplace: Scotland

MOTHER
14. Maiden name: Mary Larmon
15. Birthplace: Scotland

16. Informant: James Mackey
Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 23 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing Md

19. Dec 23 1945 (Date rec'd by registrar) D. S. Davies Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 1945, to Dec 20 1945 and that I last saw him alive on Dec. 20 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other

Address: Lonaconing, Md. Date signed: Dec. 22 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

11768

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Five Yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Patrica Ann Magruder

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Howard Magruder
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): May 6, 1902

8. AGE: Years	Months	Days	If less than one day
43	7	15	hrs. min.

9. Birthplace: Jacksonville-Duvall-Florida
(Town, county, and state)
10. Usual occupation: House work
11. Industry or business: Own-Home.

FATHER
12. Name: Not Known
13. Birthplace: " "

MOTHER
14. Maiden name: Not Known
15. Birthplace: " "

16. Informant: Howard Magruder
Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23 45 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cem.
Location: Moscow, Md.
18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. Dec. 23 19 45 (Date rec'd by registrar) Agay M. Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21, 19 45, at 615a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 19 45 to Dec 21 19 45 and that I last saw h.. alive on Dec 20 19 45

Immediate cause of death	DURATION
Acute Gastritis	2 days
Acute myocardial failure	1 "
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Norman Reed, M.D. M. D. or other
Address: Westernport, Md Date signed 12.23 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

11769

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos.

Hospital, Institution or street address where death occurred:

50 Breast St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Mineral

City or town Ridgley

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Adam Maier

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Katherine Seitz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 12 1859

8. AGE:	Years	Months	Days	If less than one day
	86	8	10	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Retired 10 yrs

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Mrs Irene Seitz

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 24 '45 (month) (day) (year)

Cemetery or crematory St. Peter & Paul Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Dec 24, 1945 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1945 at 5:29 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1945, to Dec. 22 1945 and that I last saw him alive on Dec. 21 1945

Immediate cause of death	DURATION
Bronchopneumonia	1 week
Due to Hypertensive C.V. Renal Disease	years
Due to	
Other conditions Hypertrophied Prostate.	years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Blow M. Edwards M. D. or other

Address 41 Greene St Cumberland Md (Date signed) Dec 24 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

11740

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 534 ½ Decatur St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Anna B Mc Greevy

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Bernard P. Mc Greevy
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 20 1879

8. AGE: Years	Months	Days	If less than one day
66	0	10	..... hrs. ..... min.

9. Birthplace Vale Summit Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
12. Name of father John J Creamer
13. Birthplace of father Ireland
14. Maiden name of mother Mary Manning
15. Birthplace of mother Ireland
16. Informant John B Mc Greevy
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 46 (month) (day) (year)
Cemetery or crematory St Patricks Cem
Location Cumberland
18. Funeral director Louis Stein Inc.
Address Cumberland
19. Jan 2 1946 J. P. Trumbull, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945, at 9 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 1945 to Dec. 30 1945 and that I last saw her alive on Dec. 30 1945

Immediate cause of death	DURATION
Myocardial failure	6 Mo.
Due to	
Due to Thyrotoxicosis	18 Mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arthur F. Jones M. D.
M. D. or other
Address 122 Bedford St. Date signed Dec. 31, 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-1

CERTIFICATE OF DEATH

11770

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred:
99 Maple St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 99 Maple
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Albert G. Menear

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Victoria Menear

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): May 24-1860

8. AGE: Years: 85 | Months: 6 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Preston Co. W. Va.
(Town, county, and state)

10. Usual occupation: retired carpenter

11. Industry or business

FATHER
12. Name: Phillip Menear
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Sallie McKinney
15. Birthplace: W. Va.

16. Informant: Mrs George Kennedy
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12-1945 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Dubay

Address: Frostburg, Md.

19. 12-11 1945 (Date rec'd by registrar) Mrs Dawes & Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1945, at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1940, to Dec. 10 1945, and that I last saw h. alive on Dec. 9 1945.

Immediate cause of death	DURATION
Chronic myocarditis.	4-5 yrs
Due to arterio-sclerosis Senility.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed 12-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bed)

CERTIFICATE OF DEATH

★ 11221 Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
308 Vine Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 308 Vine St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie Merkel

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John C Merkel
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 3 1861

8. AGE: Years: 84 | Months: 7 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Berlin Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Hittie
13. Birthplace: Germany

MOTHER
14. Maiden name: Dollie Muehlenberg
15. Birthplace: Germany

16. Informant: Mrs Wm Eyler
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 1 (month) (day) 45 (year)
Cemetery or crematory: Trinity Lutheran Cem
Location: Cumberland

18. Funeral director: Louis Stein Inc
Address: Cumberland

19. Jan. 1, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Dec 30 1945 and that I last saw her alive on Dec 30 1945

Immediate cause of death	DURATION
Chronic myocarditis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. A. Trevaskis M.D.
M. D. or other
Address: Cumberland Md Date signed: Dec 31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

11772

Reg. Dist. No. 9

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 hours

Hospital, institution, or street address where death occurred: Memrs Hospital

How long in hospital or institution? 19 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Jo Metz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 6, 1945

8. AGE:

Years	Months	Days	If less than one day
			19 hrs. ..... min.

9. Birthplace: Frostburg, Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Joseph Metz

FATHER — 13. Birthplace: Chicago Illinois

MOTHER — 14. Maiden name: Florence Jones

MOTHER — 15. Birthplace: National, Md

18. Informant: Mrs Joseph Metz

Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-9-45 (month) (day) (year)

Cemetery or crematory: Allegany Cem.

Location: Frostburg, Md.

18. Funeral director: M. Ridgeway

Address: Lonaconing, Md.

19. 12-7-45 (Date rec'd by registrar) Mrs Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7, 1945, at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/6, 1945 to 12/7, 1945 and that I last saw h... alive on 12/7, 1945

Immediate cause of death	DURATION
Prematurity (7th mo multiple birth)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hilda Laurl Walter M.D.

M. D. or other

Address: Frostburg Md Date signed: 12/7/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BPA)

CERTIFICATE OF DEATH

11773

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 128 Hanover Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Charles Metzger

3.(b) Social Security Number
212-24-2371

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma C Metzger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 1st 1876

8. AGE:

Years	Months	Days	If less than one day
70	4	0	..... hrs. ..... min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Barber.

11. Industry or business

FATHER
12. Name: Mark S Metzger
13. Birthplace: Buffalo Mills Pa

MOTHER
14. Maiden name: Sarah Miller
15. Birthplace: Buffalo Mills Pa.

16. Informant: John C Metzger
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 4 45 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem

Location: Cumberland.

18. Funeral director: Louis Stein Sons

Address: Cumberland.

19. Dec 4 (Date rec'd by registrar) 1945 Jos. L. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1945, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943 to December 1 1945 and that I last saw h.. alive on December 1 1945

Immediate cause of death	DURATION
Apoplectic insult	one day
Due to arterial hypertension	several
Due to chronic nephritis	3 years many years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C Weiss MD
M. D. or other

Address: Long Hist Date signed 12-2-45

11774

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Annie Martin Michaels

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph Michaels
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 15 - 1874

8. AGE: Years	Months	Days	If less than one day
71	4	17	hrs. min.

9. Birthplace: Cash Valley Allegany Cty., Md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home
FATHER 12. Name: Phillip Martin
FATHER 13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Ellen Arnold
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs Charles J Norris
Address: Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 5 - 1945 (month) (day) (year)
Cemetery or crematory: St Michael's
Location: Frostburg Md.
18. Funeral director: J. J. Durst
Address: Frostburg Md.
19. 12-4 1945 Mrs. Nancy N. Dye Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 1945, at 7:10 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Aug 19 1945, to Dec 2 1945
and that I last saw h alive on Nov 14 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to: hypertension	several months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. M. C. Lane Jr M.D.
M. D. or other
Address: Frostburg Md. Date signed: 12-4-45

Within corporate limits

11775

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 Years

Hospital, Institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 21 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 192 a. Winegow St (Rear)
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Mintdrop

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 18 7 0 Unknown

8. AGE: Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER
12. Name: Fred J Mintdrop
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Mary Unknown
15. Birthplace: Cumberland, Md.

16. Informant: Morgan Harris

Address: 111. Union St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/28/45 (month) (day) (year)

Cemetery or crematory: St Patricks Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec 27 1945 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1945, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12.11.45 1945, to 12.25.45 1945 and that I last saw h[illegible] alive on 12.22.45 1945

Immediate cause of death	DURATION
Infirmities of Age	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Simms M. D. or other

Address: Cumberland Date signed 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11776

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 58 Bowery St

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 58 Bowery
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Morgan

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

B.(b) Name of husband or wife: Lucy Morgan

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): April 8 - 1869

8. AGE:

Years	Months	Days	If less than one day
76	8	18	hrs. min.

9. Birthplace: Frostburg - Allg - Md.
(Town, county and state)

10. Usual occupation: pipe fitter

11. Industry or business: Plumbing business

FATHER
12. Name: David Morgan
13. Birthplace: Wales

MOTHER
14. Maiden name: Mary Ann Williams
15. Birthplace: Wales

16. Informant: Mrs Walter Green
Address: Lonaconing, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Dec 29-1945
(month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Dehart

Address: Frostburg, Md.

19. 12-29 1945 Mrs. Nancy N. Re
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 1945, at 7.25 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 26 1945 to Dec 26 1945 and that I last saw h.m.n alive on Dec 26 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm Lane MD
M. D. or other

Address: Frostburg Md Date signed: 12-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

11777

Reg. Dist. No. .....

M

I

VS A15 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 yrs

Hospital, Institution, or street address where death occurred:

134 South St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 134 South St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME India Catherine Mullen

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Joseph A Mullen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1873

8. AGE: Years 71 | Months 3 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John P Griffin

13. Birthplace Md

MOTHER 14. Maiden name Laura V. Johnson

15. Birthplace Md.

16. Informant Jos A Mullen

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/11/45 (month) (day) (year)

Cemetery or crematory St Patricks Cem

Location Cumberland.

18. Funeral director Louis Stein Inc

Address Cumberland

19. Dec 10 1945 (Date rec'd by registrar) Joseph B Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1945 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 7, 1945, to Dec. 7, 1945

and that I last saw her alive on Dec. 7, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas L. Burnett M. D. or other

Address Cumberland Date signed 12-8-45

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 79(a)

CERTIFICATE OF DEATH

11778

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany.

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
133 Race St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland. County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 133 Race St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Catherine Myers.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) ~~Single~~, married, widowed, or ~~divorced~~
F.	W.	Widowed.

6.(b) Name of husband ~~or wife~~ John L. Myers.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 25. 1871

8. AGE: Years	Months	Days	If less than one day
74	1	4	..... hrs. ..... min.

9. Birthplace Preston Co. W. Va.
(Town, county and state)

10. Usual occupation Housewife.

11. Industry or business Own Home.

FATHER 12. Name Christopher C. Bolyard.

FATHER 13. Birthplace W. Va.

MOTHER 14. Maiden name Martha R. Messinger

MOTHER 15. Birthplace W. Va.

16. Informant Mrs. Mildred F. Brady.

Address Cumberland, Md.

17. Burial Date thereof Dec 31 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. 12-31 1945 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1945 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1945, to Dec 29 1945

and that I last saw h alive on Dec 29 1945

Immediate cause of death	DURATION
Coronary Occlusion	4 days
Due to Arteria Sclerosis and Bronchial Asthma	5 Yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. Brown M.D. or other

Address 133 Va Ave. Date signed 12/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

within Corporate Limits
Dr. Jacobson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

11779

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 years

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Marian Street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Frances Naughton

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Edward J. Naughton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 2, 1878

8. AGE: Years	Months	Days	If less than one day
67	6	14	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Justice Grabenstein

13. Birthplace Germany

MOTHER 14. Maiden name Margaret Montay

15. Birthplace Germany

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 15, 1945 (month) (day) (year)

Cemetery or crematory Sts. Peter & Paul

Location Cumberland, Md.

18. Funeral director John L. Horn

Address Cumberland, Md.

19. Dec 18, 1945 (Date rec'd by registrar) Jos. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1945, at 5:17 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 4 1945, to Dec 15 1945 and that I last saw h. alive on Dec 15 1945

Immediate cause of death	DURATION
Coronary Occlusion	12/13/45
Due to Pulmonary edema	
Due to Pulmonary edema	
Other conditions Gangrenous Appendicitis 12/8 Post Partum Hemorrhage Abortion "	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Russell Jacobson M.D. M. D. or other

Address 15 S. Liberty St. Date signed 12/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2d

CERTIFICATE OF DEATH

11780

Reg. Dist. No. ....

1. PLACE OF DEATH:
County: Allegany
City or town: Amcelle
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Celeanese Corp. Of America
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cresaptown
(if outside city or town limits, write RURAL and give nearest town)
Street No.: Wihchester Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Cromwell Randolph Nave
3. (b) Social Security Number: 215-12-2300

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Montra Houser Nave
6.(c) If alive, give age: 43 years
7. Birth date of deceased (mo., day, yr.): Aug. 3, 1899

8. AGE: Years: 46 | Months: 4 | Days: 27 | If less than one day ....hrs. ....min.

9. Birthplace: Centreville, Penna. (Town, county, and state)
10. Usual occupation: Machinest Helper
11. Industry or business: Celeanese Corp. Of America

FATHER
12. Name: Jacob Nave
13. Birthplace: Penna.

MOTHER
14. Maiden name: Ida Deremer
15. Birthplace: Penna.

16. Informant: Mrs. Montra Nave
Address: Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2, 1946 (month) (day) (year)
Cemetery or crematory: Centreville Cem.
Location: Centreville, Penna.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. 1/2/46 (Date rec'd by registrar) 19 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30, 1945, at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...... to ....19......
and that I last saw h— Examined body 12-30-1945

Immediate cause of death	DURATION
Valvular Heart Disease	
Due to: La Grippe.	4 days.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. F. W. Snyder M.D. (M. D. or other)
Address: Cumberland Md. Date signed: 12-31-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (725)

CERTIFICATE OF DEATH

11781

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, Institution, or street address where death occurred: 437 Race St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town ~~437~~ Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 437 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Opal Pagne

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Jno E Pagne.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 6 1886

8. AGE: Years	Months	Days	If less than one day
59	8	26	..... hrs. ..... min.

9. Birthplace W. Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James E Pigton

13. Birthplace W. Va.

MOTHER 14. Maiden name Martha Hardy

15. Birthplace W. Va.

16. Informant James E. Pagne

Address Cumberland

17. Burial Date thereof Dec 4 '45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. Dec. 4 19 45 Jos. L. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2. 1945 at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19.. to Dec 2 19 45

and that I last saw h~~e~~r alive on Nov 19 45

Immediate cause of death	DURATION
Myocardial Degeneration, Acute	2 days
Due to Bronchitis	1 week
Due to Grippe, Emphysema	1 week
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos A Pagne M. D. or other

Address Cumberland Md Date signed 12/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

Within corporate limits

Evidence for the change of the year of birth of the deceased is shown on

FILM No. 100 JAN 8 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1066)

11782

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 10 Fourth St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 - 4th St.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: Chester E. Parker
3.(b) Social Security Number: ?

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Helen Helgoth
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct. 3 ~~1892~~ 1889

8. AGE: Years: 56 Months: 2 Days: 17 If less than one day ... hrs. ... min.

9. Birthplace: Paw Paw W.Va.
(Town, county, and state)
10. Usual occupation: Carman Helper
11. Industry or business: R.R. Co
FATHER
12. Name: Thomas J. Parker
13. Birthplace: Md
MOTHER
14. Maiden name: Margaret B. Strawsbaugh
15. Birthplace: Pa
16. Informant: Helen Parker
Address: Cumberland Md
17. Burial Date thereof: Dec 23 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Camp Hill Cem
Location: Paw Paw W.Va.
18. Funeral director: Louis Stein Inc
Address: Cumberland Md
19. Dec 23 1945 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1945, at 9 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Dec 20 1945
and that I last saw h im alive on Dec 20 1945

	DURATION
Immediate cause of death: Oedema R. Lung	1 wk
Due to: Chronic Bronchitis	8 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: 26 Union St Cumberland Date signed 12/21/45

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

11783

Reg. Dist. No. 4

(M)

1

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Pear Street R.R. Crossing

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 135 N Centre St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Oscar George Peters

3.(b) Social Security Number 171-07-8739

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marian Williams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 16 1905

8. AGE: Years 40 Months 5 Days 10 If less than one day ..... hrs. ..... min.

9. Birthplace Izzard Pa (Town, county, and state)

10. Usual occupation Fire Worker

11. Industry or business Kelly Springfield Tire Co

FATHER 12. Name Jos H Peters

13. Birthplace Pa

MOTHER 14. Maiden name Agnes Shirey

15. Birthplace Pa

16. Informant S E Peters

Address Altoona Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 28 1945 (month) (day) (year)

Cemetery or crematory Calvary

Location Altoona Pa

18. Funeral director Gainstein Inc

Address Cumberland Md

19. Dec 26, 1945 J. P. Franklin M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH December 26th., 1945, at 3.48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured skull; fractured 3,4,5 and 6 cervical vertebrae.	
Due to killed instantly	
Due to	
Other conditions (crushed chest; fract. leg)	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-26-45

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) R.R.

Means of injury struck by train Injured at work? no

23. SIGNATURE Prince H. Boyer, M.D. M. D. or other

Address Cumberland, Maryland Date signed 12-26-45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

11784

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 132 Mosside St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Nathan Power

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Emma M. Kenyon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 3rd. 1868

8. AGE: Years 77 | Months 1 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Frostburg, Alleg. Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Coal Miner

FATHER 12. Name John Power

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden name Rachael P. Arnold

MOTHER 15. Birthplace Conn.

16. Informant Frank Power

Address 112 Wood St. Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-15-1945 (month) (day) (year)

Cemetery or crematory St Michaels Cem

Location Frostburg, Md

18. Funeral director Jacob Kaler

Address Frostburg, Md.

19. 12-14 1945 Mrs. Harvey H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1945 at 7.40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to Dec 12 1945 and that I last saw him alive on Dec 11 1945

Immediate cause of death	DURATION
Carcinoma RT Kidney	several months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W M Lane M.D.

M. D. or other

Address Frostburg Md Date signed 12-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

11785

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Route 2 Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Barbara McKenzie Raley

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Clarence Raley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 23, 1888

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	11	17		

9. Birthplace: Pocahontas Somerset Cty., Pa.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER — 12. Name: Patrick McKenzie

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Rachel Hutzell

MOTHER — 15. Birthplace: Pennsylvania

16. Informant: Mrs. Verda McKenzie

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1945 (month) (day) (year)

Cemetery or crematory: Beal Cemetery

Location: Pocahontas Pa.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 12-12-45 Mc Haney R. Reg. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1945 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 7 — 1945 to Dec. 11 1945

and that I last saw her alive on December 11 1945

Immediate cause of death	DURATION
Broncho-Pneumonia	3 days.
Due to Chronic nephritis	—
Due to Diabetic Militus	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl M.D.
M. D. or other

Address: Frostburg Md. Date signed 12/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

Dr Gracie

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-a

CERTIFICATE OF DEATH

11786

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or Institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. VA. County GRANT

City or town MAYSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME MR. WILLIAM D. REEL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife RUMANIA MAY

6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) JUNE 30, 1861

8. AGE:

Years	Months	Days	If less than one day
84	5	28	hrs. min.

9. Birthplace Grant County, West Virginia
(Town, county and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William D. REEL
13. Birthplace WEST VIRGINIA,

MOTHER
14. Maiden name EVA SCHELL
15. Birthplace WEST VIRGINIA

16. Informant Memorial Hosp.
Address Cumberland, Md.

17. Burial
(Burial, cremation, or removal, Which) Date thereof Dec 31, 1945 (month) (day) (year)

Cemetery or crematory McDonald Cem.

Location Maysville, W. Va.

18. Funeral director P. E. Thrush

Address Petersburg, W. Va.

19. Dec. 31, 1945 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 28, 1945, at 10:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC. 16, 1945, to DEC. 28, 1945 and that I last saw him alive on DEC. 28, 1945

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to Fractured Intra-Capsular Leg	
Due to Accidental Fall	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Lungs, Heart & Liver congested

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Fall — Injured at work?

23. SIGNATURE W. G. Gracie
M. D. or other

Address Cumberland Md Date signed 12-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

(M)

MARGIN RESERVED FOR BINDING

(I)

(7)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11787 ★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 yrs.

Hospital, Institution, or street address where death occurred:
324 Emily St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 324 Emily St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George William Reid

3.(b) Social Security Number: 214-07-6141

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella Farrell

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: Years: 77 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Engineering Dept.

11. Industry or business: C. C. & A.

FATHER
12. Name: Robert Reid
13. Birthplace: Md

MOTHER
14. Maiden name: Bridget Mantz
15. Birthplace: Md

16. Informant: John Reid
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 14 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland

18. Funeral director: Louis Stein Jr.

Address: Cumberland

19. Dec 14 1945 (Date rec'd by registrar) Jos. T. Franklin, M.D. Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: December 12th., 1945, at 4 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____, 19____, to ____, 19____, and that I last saw h ____ alive on ____, 19____.

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Diher conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Prince H. Bolgan, M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 12-12-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

11788 4
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred:
Allegany Co Infirmary
How long in hospital or institution? 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 320 S. Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Agnes Rickard

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Joseph Rickard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 19 1886

8. AGE: Years	Months	Days	If less than one day
59	2	16	..... hrs. ..... min.

9. Birthplace Frostburg Md
(Town, county and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Dennis O'Hara
13. Birthplace Ind.
MOTHER 14. Maiden name Jenette Nelson.
15. Birthplace Ind
16. Informant James E. Rickard
Address Cumberland
17. Burial (Burial, cremation, or removal? Which?) Date thereof 12 7 45 (month) (day) (year)
Cemetery or crematory St Patricks Cem.
Location Cumberland
18. Funeral director Louis Stein Sons
Address Cumberland
19. Dec. 6 1945 Jos. L. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1945 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. 1945, to Dec. 5. 1945
and that I last saw her alive on Dec. 1. 1945

Immediate cause of death	DURATION
Coronary Thrombosis	.....
Due to Generalized Arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE K. F. Williams M. D. or other
Address Cumberland Date signed 12-6-45

Wallcains

Within corporate limits ✓ Dr. Eliason

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11784

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 yrs
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 45 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 517 Linden Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Carolina Riley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank M. Riley
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): November 21 1871

8. AGE: Years	Months	Days	If less than one day
73	—	28	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Conrad Zelch
13. Birthplace: Germany

MOTHER
14. Maiden name: Josephine Workman
15. Birthplace: Germany

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Buried (Burial, cremation, or removal, which) Date thereof Dec 21 '45 (month) (day) (year)
Cemetery or crematory: St Patricks Cem
Location: Cumberland Md
18. Funeral director: Louis Stein Inc
Address: Cumberland

19. Dec 21, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19, 1945 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 1945 to 12-19-1945 and that I last saw h.. alive on 12-18-1945

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to Chronic Myocarditis	
Due to Arteriosclerosis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 12-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (I) (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

11790

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred: 203 Spruce St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 203 Spruce
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Rinehart
3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: John A. Rinehart, Sr.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 3, 1868.
8. AGE: Years 77, Months 3, Days 18. If less than one day ... hrs. ... min.
9. Birthplace: Elm-Grove-Ohio-W.Va. (Town, county, and state)
10. Usual occupation: House-work
11. Industry or business: Own-Home
FATHER 12. Name: John Smith
13. Birthplace: Not known
MOTHER 14. Maiden name: Not Known
15. Birthplace: Not Known
16. Informant: John A. Rinehart
Address: Westernport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 23, 45 (month) (day) (year)
Cemetery or crematory: Philos Cemetery
Location: Westernport, Md.
18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.
19. Dec. 23 1945 (Date rec'd by registrar) Glazinbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1945 to Dec 21 1945 and that I last saw her alive on Dec 18 1945

Immediate cause of death: Chronic Myocarditis | DURATION 2 yr
Myo[illegible] [illegible] degeneration | 6 mo.
Due to
Due to
Other conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [illegible] M.D. or other
Address [illegible] W.Va. Date signed 12/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

11791

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Alleg.

City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mardell Laure ~~Baldwin~~ Robinson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-1945

8. AGE:

Years	Months	Days	If less than one day
—	—	8	hrs. min.

9. Birthplace Midalon Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Allendle ~~Wallace~~ Robinson

FATHER 13. Birthplace Fredrick Twn Pa

MOTHER 14. Maiden name Beulah Durst

MOTHER 15. Birthplace Fort Hill R D 1 Pa

16. Informant Russell Durst

Address Midalon

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-31-1945 (month) (day) (year)

Cemetery or crematory Saint Paul

Location Fort Hill R.D 1 Pa

18. Funeral director Wm. Winterberg

Address Grantsville Md

19. 12-31 1945 Mrs. Lauey H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1945, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 29 1945, to December 31 1945; and that I last saw h... alive on December 30 1945.

Immediate cause of death	DURATION
Premature birth 6 mos. wt: 1lb 15oz.	1 week.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. Diehl, M.D.
M. D. or other

Address Frostburg, Md. Date signed 12/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-a

11792

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Franklin Jr. "Rural"
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 x yrs

Hospital, Institution, or street address where death occurred: 2 Mi North of Westernport.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Franklin "Rural"
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 mi North of Westernport.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Margaret Virginia Ross

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Robert Ross

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 12, 1875

8. AGE:

Years	Months	Days	If less than one day
70	11	11	..... hrs. ..... min.

9. Birthplace: Moorfield - Grant - W. Va
(Town, county, and state)

10. Usual occupation: Home - work

11. Industry or business

FATHER
12. Name: David Arnold
13. Birthplace: W. Va

MOTHER
14. Maiden name: not known
15. Birthplace: " "

16. Informant: Dewey Dickinson
Address: Franklin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 26 1945 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport Md

18. Funeral director: Ellsworth S. Brady

Address: Westernport Md.

19. Dec. 25 45 (Date rec'd by registrar) Raymond Barr M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23 1945, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 1945, to Dec 23 1945

and that I last saw her alive on Dec 23 1945

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to: Influenza	10 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James H. Ellsworth M.D. M. D. or other

Address: Piedmont W. Va. Date signed Dec 24, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-C

CERTIFICATE OF DEATH

11793

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 80 Bowery Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ruth Ann Ross

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Child

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 31, 1943

8. AGE: Years: 1 | Months: 11 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Frostburg, Allegany, Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Lewis Ross

FATHER — 13. Birthplace: Lonaconing Md.

MOTHER — 14. Maiden name: Martha Richardson

MOTHER — 15. Birthplace: Frostburg, Maryland

16. Informant: Mrs. Lewis Ross

Address: 80 Bowery St. Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 - 10 - 1945 (month) (day) (year)

Cemetery or crematory: Allegany Co.

Location: Frostburg, Md.

18. Funeral director: Jacob H. Kafer

Address: Frostburg Md.

19. 12-10 1945 Mrs. Nancy N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1945, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 30 1945, to Dec 8 1945 and that I last saw her alive on Dec 8 1945

	DURATION
Immediate cause of death: Meningitis (Influenzal)	2 days
Due to: Pneumonia (Influenzal)	10 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. E. Gattens M.D.

M. D. or other

Address: Frostburg Md. Date signed: 12/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

11794

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 Mullen St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Morry Addison Runion

3.(b) Social Security Number: 705-05-7525

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Olie V. Monteith

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 7 1891

8. AGE:

Years	Months	Days	If less than one day
54	11	9	____ hrs. ____ min.

9. Birthplace: Mansfield W. Va. (Town, county, and state)

10. Usual occupation: Patrolman

11. Industry or business: B. & O. Ry.

FATHER — 12. Name: Addison Runion

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Sallie Bobo

15. Birthplace: W. Va.

16. Informant: Mrs Irene A. Runion

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20 45 (month) (day) (year)

Cemetery or crematory: Ft. Oakley Cem

Location: Ft. Oakley W. Va.

18. Funeral director: Louis Stein Sons

Address: Cumberland

19. Dec. 20, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 1945 at 4 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20, 1945 to Dec. 16, 1945 and that I last saw him alive on Dec. 16, 1945

Immediate cause of death	DURATION
(a) Adeno-Carcinoma of Prostate	2 yrs
Due to (b) Generalized Metastasis	(Hours)
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Adeno-Carcinoma

Date of op. Sept 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Clay R. Turner M. D. or other

Address: Cumberland Date signed: 12-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

11795

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 yrs

Hospital, Institution, or street address where death occurred: Allegany Co. Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 206 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Anna Belle Ryland.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 17 1859

8. AGE:

Years	Months	Days	If less than one day
86	7	20	..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business

FATHER — 12. Name: Andrew Ryland

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary Harrison

15. Birthplace: Md.

16. Informant: Joseph Ryland

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4, 1945 (month) (day) (year)

Cemetery or crematory: St. Patrick's Cem.

Location: Cumberland, Md

18. Funeral director: Louis Stein Inc

Address: Cumberland, Md.

19. Dec 3, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 1945, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1942, to Dec 2 1945

and that I last saw h.. alive on Dec 1 1945

Immediate cause of death: Generalized Arteriosclerosis

Due to:

Due to: Infirmities of age.

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D.

Address: Cumberland Date signed: 12-3-45

WITHIN CORPORATE LIMITS

(M)

Wallaces

MARGIN RESERVED FOR BINDING

(I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-a)

CERTIFICATE OF DEATH

11796

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 15 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: Bedford

City or town: Buffalo Mills, Rt. 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Hazel Sanner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

B.(b) Name of husband or wife: Amos Sanner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 1st, 1902

8. AGE: Years	Months	Days	If less than one day
43	8	8	..... hrs. ..... min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Miles Pittenger

13. Birthplace: Pa

MOTHER — 14. Maiden name: Minnie Goff

15. Birthplace: Pa.

18. Informant: Amos W. Sanner

Address: Buffalo Mills Rt. 1 Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12 1945 (month) (day) (year)

Cemetery or crematory: Pale Alto

Location: Hyndman Rural, Pa

18. Funeral director: J. N. H. Leigh

Address: Hyndman Pa

19. Dec 11 1945 (Date rec'd by registrar) Jos. G. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1945 at 12:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9 1945, to December 9 1945 and that I last saw h.e alive on December 9 1945

	DURATION
Immediate cause of death: ruptured uterus	45 min.
Due to: hydrocephalic baby	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Extraperitoneal rupture of lower uterine segment Date of op. 12-8-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: L. Blair M.D. (M. D. or other)

Address: Long Mod Date signed 12-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119)

CERTIFICATE OF DEATH

11797

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Pear St. Crossing, B & O R.R.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Alleg.
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 135 N. Centre St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ada C. Sawyers

3.(b) Social Security Number 214-05-7053

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Div.

6.(b) Name of husband or wife John J. Sawyers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 18 1902

8. AGE: Years	Months	Days	If less than one day
43	3	8	..... hrs. ..... min.

9. Birthplace Midland, Md.
(Town, county, and state)
10. Usual occupation Clerk
11. Industry or business
FATHER 12. Name William Close
13. Birthplace Md.
MOTHER 14. Maiden name Elizabeth Askey
15. Birthplace Md.
16. Informant James Close
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 28 1945 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland, Md.
18. Funeral director Louis Stein Inc.
Address Cumberland, Md.
19. Dec. 28, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH December 26th, 1945 at 3.48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured skull; fract 4.5, and 6th Cervical vertebrae; Crushed left chest.	killed instantly
Due to	
Due to	
Other conditions: Crushed left leg, middle third	

(Include pregnancy within 3 months of death)

Major findings of operations --
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 12-26-45
Where did injury occur? Cumberland, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Rail Road.
Means of injury struck by train Injured at work? no

23. SIGNATURE Louis H. Bourne, M.D.
M. D. or other
Address Cumberland, Maryland Date signed 12-26-45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Dr. Williams

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

11798

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Little Orleans
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs. Effie Smith

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Russell Smith

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 5, 1885

8. AGE: Years	Months	Days	If less than one day
60	7	28	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Reverend A. R. Garland

FATHER 13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Sarah Bishop

MOTHER 15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 5, 1945 (month) (day) (year)

Cemetery or crematory: Fairview Christian Cem.

Location: Inglesmith, Penna.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec 5 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3, 1945, at 7:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 26 1945 to Dec 3 1945

and that I last saw her alive on Dec. 2 1945

Immediate cause of death	DURATION
Acute Myocarditis	2 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland — Date signed: 12-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

11799

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 544 Green Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME ~~Baby boy~~ Louis Claude Soethe, Jr.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 24, 1945

8. AGE: Years | Months | Days | If less than one day ..... hrs. 45 min.

9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Louis C. Soethe
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden name Marian Emmart
15. Birthplace West Virginia Davis

16. Informant Louis C. Soethe
Address 544 Greene St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/27/45 (month) (day) (year)
Cemetery or crematory St Peter & Paul Cemetery
Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. Dec. 27 1945 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1945 at 7:15A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24 1945, to Dec. 24 1945 and that I last saw him alive on Dec. 24 1945

Immediate cause of death	DURATION
Premature Birth	
5½ months	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M. D. M. D. or other
Address 4 Green St. Date signed Dec 4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

Within corporate limits

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-a

CERTIFICATE OF DEATH

11800

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rear 409 Bedford St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. FLORENCE ~~Sommerville~~ Sommerville

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife WILLIAM ~~SOMMERVILLE~~ Sommerville
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown 1872

8. AGE: Years	Months	Days	If less than one day
73	?	?	____ hrs. ____ min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation AT THE COUNTY HOME
11. Industry or business

FATHER
12. Name JOSEPH ANDREWS
13. Birthplace MARYLAND

MOTHER
14. Maiden name ELIZABETH JONES
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/45 (month) (day) (year)
Cemetery or crematory Laureal Hill Cemetery
Location Lonaconing, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. Dec. 24, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 22 19 45 at 2:23 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-19-45 to 12-22-45
and that I last saw h[illegible] alive on 12-21-45

Immediate cause of death	DURATION
Gangrenous Anemia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or Other
Address Cumberland Date signed 12/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11801

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1/2 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Stevens

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 7, 1944

8. AGE: Years	Months	Days	If less than one day
1	0	15	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Charles Stevens
13. Birthplace: Maryland

MOTHER
14. Maiden name: Dorothy Wharton
15. Birthplace: Maryland

16. Informant: Charles Stevens
Address: Mt Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24 1945 (month) (day) (year)
Cemetery or crematory: St Patricks
Location: Mt Savage, Md

16. Funeral director: John J. Lamont
Address: Frostburg, Md

19. Dec. 22 1945 (Date rec'd by registrar) Joseph D. Inglis, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1945, at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 1945 to December 22 1945 and that I last saw him alive on December 22 1945

Immediate cause of death	DURATION
Lobar Pneumonia.	5 days.
Due to	
Due to	
Other conditions	

(Include pregnency within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please nuderline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William E. Moseley
M. D. or other
Address: Mt Savage Md. Date signed 12-22-45

Within corporate limits

ER. MANCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105)

CERTIFICATE OF DEATH

11802

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 minutes

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MD. County GARRETT

City or town VINDEX (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME FLORENCE REBECCA STEWART

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 7, 1934

8. AGE: Years	Months	Days	If less than one day
11	6	15	hrs. min.

9. Birthplace VINDEX, MD. (Town, county, and state)

10. Usual occupation STUDENT

11. Industry or business 5th. Grade elementary

FATHER 12. Name WALTER FRANK STEWART

13. Birthplace Elk Garden, W.Va.

MOTHER 14. Maiden name STEWART, FLORENCE

15. Birthplace Elk Garden, W.Va.

16. Informant Mrs. Walter Stewart

Address Vindex, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 26, 1945 (month) (day) (year)

Cemetery or crematory Nethken Hill Cemetery

Location Elk Garden, W.Va.

18. Funeral director Otha F. Sharpless

Address Blaine, W.Va.

19. Dec. 26, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 22 19 45 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Dec 19 45 to 22 Dec 19 45

and that I last saw h. alive on 22 Dec 45 19

Immediate cause of death	DURATION
Laryngeal Spasm	
Due to Unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. Mance, M.D. M. D. or other

Address Oakland Md Date signed 24 Dec 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11803

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Bedford Road, R. F. D. #3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Blair

City or town: Martinsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Hannah S. Stonerook

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John B. Stonerook

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 6, 1861

8. AGE: Years	Months	Days	If less than one day
84	4	8	..... hrs. ..... min.

9. Birthplace: Henrietta, Blair County, Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: William Glass
13. Birthplace: Henrietta, Penna.

MOTHER
14. Maiden name: Elizabeth Stoudnour
15. Birthplace: Henrietta, Penna.

16. Informant: Ray Glass

Address: R. F. D. #3, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 17, 1945. (month) (day) (year)

Cemetery or crematory: Mt. Pleasant Cem.

Location: R. F. D. #1, Martinsburg, Penn

16. Funeral director: K. R. Miller

Address: Martinsburg, Penna.

19 Dec. 14, 19 45 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 19 45 at 5:05 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 19 45, to Dec 14 19 45 and that I last saw h.er alive on Dec 11 19 45

Immediate cause of death	DURATION
(a) Cerebral embolism	
Due to:	
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: ←

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. Lester M. D. or other

Address: 122 Bedford St Date signed: 12/14/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-a)

11804

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hrs.
Hospital, institution, or street address where death occurred:
Allegany Hospital, Cumberland, Maryland
How long in hospital or institution? 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 230 Cecelia St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: John E Stottlemyer Jr.
3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 12/13/45

8. AGE:

Years	Months	Days	If less than one day
—	—	—	6 hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)
10. Usual occupation: Infant
11. Industry or business
FATHER 12. Name: John Stottlemyer, Sr.
13. Birthplace: Md.
MOTHER 14. Maiden name: Betty Bolinger
15. Birthplace: Md.
16. Informant: John E. Stottlemyer, Jr.
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 14 '45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland.
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.
19. Dec. 14 1945 J. P. Franklin M. D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/13 1945, at 5:15 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 13 1945 to Dec. 13 1945 and that I last saw him alive on Dec. 13 1945

Immediate cause of death	DURATION
Congenital Atelectasis	6 hrs.
Due to Small underweight infant.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. P. Franklin M. D.
M. D. or other
Address: Dec. 14 45 Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11805

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-1

1. PLACE OF DEATH:

County Allegany

City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 years

Hospital, institution, or street address where death occurred:
Route 2 Cumberland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Wilda "Ross" Strong

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Joseph M. Strong

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) August 26, 1868

8. AGE:

Years	Months	Days	If less than one day
77	3	22	...hrs. ...min.

9. Birthplace Rush, Md. (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business Own home

FATHER 12. Name John Ross

FATHER 13. Birthplace Town Creek, Md.

MOTHER 14. Maiden name Wilson

MOTHER 15. Birthplace Morleys Branch

16. Informant Joseph Earl Strong

Address Route 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22 1945 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Dec 21 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1945 at 5:00 A M

21. I CERTIFY that death occurred on this date above stated; that I attended deceased from Jan 4 1940 to Dec 18 1945 and that I last saw her alive on Dec 17 1945

	DURATION
Immediate cause of death Cerebral Apoplexy	3 mos
Due to Arteriosclerosis & Chronic Valvular Heart Disease	24 Yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. R. Owens M. D. or other

Address 133 Va Ave Date signed 12/18/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11806 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13. Years

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ALLEG. CO. HOME
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HARRY TOWNSEND

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: Theresa Townsend

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 7 1868

8. AGE: Years	Months	Days	If less than one day
77	10	3	..... hrs. ..... min.

9. Birthplace: Lancaster Co, Penna
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: Sawmill

FATHER
12. Name: JOHN TOWNSEND
13. Birthplace: Lancaster Co, Pa

MOTHER
14. Maiden name: ELIZA SOWERS
15. Birthplace: Lancaster Co, Pa

16. Informant: H. W. Matheney, Supt County Infirmary
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/11/45 (month) (day) (year)

Cemetery or crematory: Allegany County Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec. 11 19 45 (Date rec'd by registrar) Jas. B. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-10-1945 at 1 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-24-1945 to 12-10-1945 and that I last saw him alive on 12-9-1945

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: Benign Hypertrophy of Prostate	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 12-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

Dr. Eliason

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

CERTIFICATE OF DEATH

11807

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 713 Lincoln Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mr. Charles W. Tupper

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8.(b) Name of husband or wife: Myrta Wheat
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 22 1863

8. AGE: Years	Months	Days	If less than one day
82	1	4	hrs. min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: John Tupper
13. Birthplace: New York

MOTHER
14. Maiden name: Lydia Fairbrother
15. Birthplace: New York

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 28, 1945 (month) (day) (year)
Cemetery or crematory: Elmira Cem
Location: Elmira, New York
18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Dec 28, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26, 1945 at 6:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-2- 1941 to 12-26 1945
and that I last saw h... alive on 12-25 1941

Immediate cause of death	DURATION
Coma Myocardial	5 yrs
Chron. Nephritis	2 yrs
Due to: Arteriosclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. L. Eliason M. D. or other
Address: 26 Fayette St Cumberland Md Date signed: 12/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. WILLIAMS

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

★ 118084 Reg. Dist. No.

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND, MD (If outside city or town limits, write RURAL and give nearest town)
Street No. 20 WINEOW ST. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR JOHN H. TWIGG

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ISABELLE KLIPSTEIN 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 21 1864

8. AGE: Years	Months	Days	If less than one day
81	7	1	..... hrs. ..... min.

9. Birthplace MD. (Town, county, and state)
10. Usual occupation UNABLE TO WORK
11. Industry or business
FATHER 12. Name JOHN TWIGG
13. Birthplace MD.
MOTHER 14. Maiden name MASIE TWIGG
15. Birthplace MD.
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 7, 1945 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md,
18. Funeral director Charles L. George
Address Cumberland, Md.
19. Dec 6 1945 Jos. L. Franklin M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 5, 1945 1945, at 2AM M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 11-30 1945 to 12-5-45 1945 and that I last saw h... alive on 12-4-45 1945

Immediate cause of death	DURATION
Broncho Pneumonia	?
Due to Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. Other
Address Cumberland Date signed 12-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(H) MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS
From

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11809

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

415 Independence St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 Independence St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Elmer Valentine

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary E. Krause

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 11, 1878

8. AGE: Years	Months	Days	If less than one day
67	10	22	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co., Md (Town, county, and state)

10. Usual occupation Retired Fireman

11. Industry or business Kelley Springfield Tire Co.

FATHER 12. Name Abraham Valentine

13. Birthplace Cumberland Md

MOTHER 14. Maiden name Rebecca Romig Valentine

15. Birthplace Harrisburg, Pa.

16. Informant Raymond Valentine

Address 632 Elm St, Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 5, 1945 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Dec. 5, 1945 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 17, 1945, to Dec 3, 1945

and that I last saw h... alive on Nov 24, 1945

Immediate cause of death	DURATION
Chronic myocarditis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE P. F. Trewaskis, M.D. M. D. or other

Address Cumberland, Md Date signed Dec 5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

11810

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 yrs.
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 726 Bedford St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John George Wagner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Catherine J. Lendinger
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov 19 1873

8. AGE: Years	Months	Days	If less than one day
72	—	24	____ hrs. ____ min.

9. Birthplace: Cumberland Md.
(Town, county, and state)
10. Usual occupation: Retired Ry Worker
11. Industry or business:
FATHER — 12. Name: Wagner
13. Birthplace:
MOTHER — 14. Maiden name: Sophia Damm
15. Birthplace:
16. Informant: Miss Helen Wagner
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 16 '45 (month) (day) (year)
Cemetery or crematory: St Patrics Cem.
Location: Cumberland
18. Funeral director: Louis Stein Jos
Address: Cumberland
19. Dec. 15, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: December 13th., 1945 at 9.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Fractured skull, left temporal region.	20 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no operation Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: under investigation Date of 12-13-45
Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): street
Means of injury: struck by truck Injured at work? no

23. SIGNATURE: Pierce H. Lonsway M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 12-14-45

Asst. Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11817

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robert Walker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Smith
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 5, 1861

8. AGE:

Years	Months	Days	If less than one day
84	6	26	..... hrs. ..... min.

9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: Employee
11. Industry or business: Browning Product Corp Detroit

FATHER
12. Name: David Walker
13. Birthplace: Scotland

MOTHER
14. Maiden name: unknown
15. Birthplace: Unknown

16. Informant: Robert Walker
Address: Detroit, Mich

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 4 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md

18. Funeral director: M. Fitchhorn
Address: Lonaconing, Md

19. Dec 5 1945 (Date rec'd by registrar) D. E. Bowman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1945, at 1:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28 1945, to Dec 1st 1945, and that I last saw him alive on Dec 1st 1945.

Immediate cause of death	DURATION
Nephritis Uraemia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other
Address: Lonaconing, Md Date signed Dec 4 '45

Within corporate limits

Elizabeth Bringe

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

11812 4

Reg. Dist. No.

M

I

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. No. 1 Braddock Farms
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr. John W. Walter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary A. Norris
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): April 10, 1874

8. AGE: Years	Months	Days	If less than one day
71	8	8	...hrs. ...min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Pensioned
11. Industry or business: B. & O. Railroad

FATHER
12. Name: Francis Walter
13. Birthplace: Unknown

MOTHER
14. Maiden name: Larina Judy
15. Birthplace: Unknown

16. Informant: Mrs Lula Hughes
Address: R. D. #1 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22, 1945 (month) (day) (year)
Cemetery or crematory: Garrett Cemetery
Location: Garrett, Penna.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Dec 20 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18th 1945 at 7:00P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 1945 to December 18 1945 and that I last saw him alive on December 18 1945

Immediate cause of death	DURATION
Uremia	
Due to carcinoma of the pancreas head	
Due to	
Other conditions Myelanoid apathia	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Bringe M.D.
M. D. or other
Address: Coupled Date signed 12/19

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-a

CERTIFICATE OF DEATH

11813

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ Months.

Hospital, Institution, or street address where death occurred: Route 2 Cumberland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County

City or town Near Elkins W. Va.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mrs Millie White

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife A. B. White

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 18, 1860

8. AGE:

Years	Months	Days	If less than one day
85	1	15	..... hrs. ..... min.

9. Birthplace Rockingham County, Va. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER 12. Name James F. Payne

13. Birthplace Va.

MOTHER 14. Maiden name Mary Campbler

15. Birthplace England.

16. Informant Mrs. Wm O. McElfish

Address Route 2 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 8, 1945 (month) (day) (year)

Cemetery or crematory Mt. Clinton Mennonite Cemetery

Location Near Harrisonburg, Va.

18. Funeral director John J Hofer

Address Cumberland Md.

19. Dec. 5, 1945 (Date rec'd by registrar) Jos. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1945, at 1:07 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 19.. to Dec 2 19.45

and that I last saw h.. alive on Nov 26 19.45

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. A. Iwaskis M.D. M. D. or other

Address Cumberland, Md Date signed Dec 5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1945 - 11 - 33
1860 - 10 - 18
85 - 1 - 15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11814

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hours

Hospital, institution, or street address where death occurred:
Miners Hospital

How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Frostburg - star route
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Winbrenner

3.(b) Social Security Number none

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Laura Winbrenner

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): September 5 1870

8. AGE: Years 75 | Months 3 | Days 23 | If less than one day: hrs. min.

9. Birthplace: Long Stretch Garrett Cty., Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Isaac Winbrenner

13. Birthplace: Maryland

MOTHER 14. Maiden name: Margaret Crowe

15. Birthplace: Maryland

16. Informant: Francis Crowe

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Garrett County, Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md

19. 12-29 (Date rec'd by registrar) 19 45 Mrs. Valley A. Poe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 19 45 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27 19 45, to Dec. 29 19 45.

and that I last saw him alive on December 28 19 45.

Immediate cause of death	DURATION
Acute myocarditis.	1 day.
Due to Cold.	
arterio-sclerosis.	
Due to Chronic nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.
M. D. or other

Address: Frostburg, Md. Date signed 12/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (914a)

CERTIFICATE OF DEATH

11815

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Pinto

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Norman Solomon Yoder

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Anna M. Yoder

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) January 24, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	10	9	...hrs. ...min.

9. Birthplace Garrett Co. Md. (Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business General farming

FATHER 12. Name Solomon Yoder

13. Birthplace Unknown

MOTHER 14. Maiden name Catherine Yutzy

15. Birthplace Pocahontas, Pa

16. Informant Walter Yoder

Address Rt. 5, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 6 1945 (month) (day) (year)

Cemetery or crematory Mennonite Cemetery

Location Pinto, Md

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Dec. 6, 1945 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1945 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1942, to December 3 1945 and that I last saw h[er] alive on December 3 1945

Immediate cause of death	DURATION
acute coronary occlusion	one day
Due to, or as a consequence of: cerebral hemorrhage	
Due to, or as a consequence of:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Bruce M.D. M. D. or other

Address Long Lane Date signed 12-4-45

M

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11816

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 8 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 83 W. Loo St.
(If rural, give LOCATION)

2.(a) If veteran, name war: W. W. I

3.(a) FULL NAME: Benjamin Leroy Barger

3.(b) Social Security Number: 214-07-4830

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary Barger

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): April 17, 1893

8. AGE: Years: 52 | Months: 7 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Chambersburg Franklin Cty Pa.
(Town, county, and state)

10. Usual occupation: sheet metal worker

11. Industry or business: Celanese Corp.

FATHER — 12. Name: Benjamin Barger

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Mary J. Kramer

MOTHER — 15. Birthplace: Pennsylvania

16. Informant: Howard R. Barger

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 12-12 1945 W. Hawley H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1945 to Dec. 11 1945 and that I last saw him alive on December 11 1945

Immediate cause of death	DURATION
Carcinoma of stomach and liver	
Due to: Chronic nephritis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.
M. D. or other

Address: Frostburg, Md. Date signed: 12/12/45

Within corporate limits: [illegible] NOON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

11817

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 HOLLAND ST.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MRS. GRACE ZEMBOWER

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife A. GERALD ZEMBOWER

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) FEB. 23, 1880

8. AGE: Years	Months	Days	If less than one day
65	9	25	...hrs. ...min.

9. Birthplace PENNA.
(Town, county, and state)

10. Usual occupation HWFE.

11. Industry or business

FATHER
12. Name FRANK KELLY
13. Birthplace PENNA.

MOTHER
14. Maiden name MARTHA HITE
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 20 '45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Dec. 20, 1945 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 18, 1945, at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-16-1945 to 12-18-1945 and that I last saw h...er alive on 12-18-1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Chronic Myocardial Disease	
Due to Diabetes Mellitus (Degeneration)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 12-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

CERTIFICATE OF DEATH

11818

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred: 508 N. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 508 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Margaret Ann Zink

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John Zink

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1872

8. AGE:	Years	Months	Days	If less than one day
	73	9	20	..... hrs. ..... min.

9. Birthplace Frostburg, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name Christian Lehr
13. Birthplace Germany

MOTHER
14. Maiden name Margaret Gerlach
15. Birthplace Germany

16. Informant Mrs Sada Means

Address 508 N. Mechanic St, Cumb. Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof December 6 1945
(month) (day) (year)

Cemetery or crematory St Lukes Lutheran

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Dec. 5, 1945
(Date rec'd by registrar)

Jos. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 20 1945 to December 15 1945

and that I last saw h... alive on 11/15 1945

Immediate cause of death	DURATION
Heart failure	
Due to Myocardiopathia	
arteriosclerotic	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Elizabeth Bruce M.D.
M. D. or other

Address ..... Date signed 12/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11819

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 9

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Allegheny

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs.

Hospital, Institution, or street address where death occurred:

Miners Hosp.

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Beall St. Ext.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. MARY ZUMPANO

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Ezequiel Zumpano

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Apr. 22-1888

8. AGE: Years	Months	Days	If less than one day
57	8	2	....hrs. ....min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Joseph Cermone

FATHER — 13. Birthplace: Italy

MOTHER — 14. Maiden name: Rae Cepuso

MOTHER — 15. Birthplace: Italy

16. Informant: Mary Zumpano

Address: Beall St. Ext. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-27-1945 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg, Maryland

18. Funeral director: Jacob Dakes

Address: Frostburg Md.

19. 12-26 1945 Mrs. Nancy H. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 24 1945 at 3:11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC. 11 1945 to DEC. 24 1945 and that I last saw her alive on DEC. 24 1945

Immediate cause of death	DURATION
CARDIAC FAILURE WITH DECOMPENSATION	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: .... Injured at work?

23. SIGNATURE: John Sparella M. D. or other

Address: 1 E. Main St., Frostburg Md. Date signed 12/24/45